SUBJECT: Creating the Chronic Kidney Disease Task Force

COMMITTEE: Public Health — committee substitute recommended

VOTE: 9 ayes — Delisi, Laubenberg, Jackson, Cohen, Coleman, Gonzales, S. King, Olivo, Truitt

0 nays

WITNESSES: For — Rita Littlefield, Texas Renal Coalition; Marolyn W. Stubblefield, National Kidney Foundation (NKF); Sister Michele O'Brien; *(Registered, but did not testify*: Jennifer Banda, Texas Hospital Association; Tom Banning, Texas Academy of Family Physicians; Greg Herzog, Texas Medical Association; Greg Hooser, Texas Dietetic Association; Carrie Kroll, Texas Pediatric Society; Gabriela Moreno, Christus Health; Laurie Reece, Texas Transplant Society; Joel Romo, American Heart Association, Texas Public Health Coalition; Samuel Stubblefield

Against — None

On — Jann Melton-Kissel, Department of State Health Services

BACKGROUND: Kidney disease is the fourth leading cause of death in the U.S. today, affecting one in nine adults. Chronic kidney disease includes conditions that damage the kidneys and decrease their ability to remove waste from the bloodstream. Complications that may develop as a result of kidney disease include high blood pressure, anemia, weak bones, poor nutritional health, nerve damage, and an increased risk of having heart and blood vessel disease. The two main causes of chronic kidney disease are diabetes and high blood pressure, which are responsible for up to two-thirds of the cases.

DIGEST: CSHB 1371 would add Health and Safety Code, ch. 98, establishing the Chronic Kidney Disease Task Force. The task force would have 17 members, including two senators appointed by the lieutenant governor; two House members appointed by the speaker of the House; and the following 13 members appointed by the governor:

- one family practice physician;
- one pathologist;
- one nephrology department representative from a state medical school;
- one nephrologist in private practice;
- two representatives from different Texas affiliates of the National Kidney Foundation;
- one representative from the Department of State Health Services (DSHS);
- one representative of an insurer that issues a preferred provider benefit plan or of a health maintenance organization (HMO);
- one representative of clinical laboratories;
- one representative of private renal care providers;
- one pediatrician in private practice;
- one kidney transplant surgeon; and
- one representative from the Texas Renal Coalition.

The governor would designate the presiding officer of the task force, who would serve at the will of the governor. The bill further would require all appointments to the task force be made without regard to the race, color, disability, sex, religion, age, or national origin of the appointees.

The Chronic Kidney Disease Task Force would perform the following duties:

- develop a plan to educate health care professionals about early screening, diagnosis, treatment, and complications related to chronic kidney disease based on medically recognized clinical practice guidelines;
- develop a plan to educate health care professionals and individuals with chronic kidney disease about the advantages of end-stage renal disease modality education, early renal replacement therapies, and transplantation, before the onset of end-stage renal disease; and
- make recommendations on the implementation of a cost-effective, statewide plan for early screening, diagnosis, and treatment of chronic kidney disease.

The bill would not provide compensation to members of the task force, but would allow DSHS to reimburse members for actual and necessary expenses as a result of attending task force meetings and performing other

official duties. To support its operations, the task force could accept gifts and grants from individuals, public or private organizations, or federal or local funds.

The bill would require DSHS to provide administrative support to the task force, including staff and meeting facilities, as well as investigate potential sources of federal funding.

The bill would require the Chronic Kidney Disease Task Force to submit its findings to the governor, lieutenant governor, speaker of the House, and the chairs of the Senate Health and Human Services and House Public Health committees no later than January 1, 2009.

The bill would exempt the task force from requirement for state advisory committees under Government Code, ch. 2110 and would abolish the Chronic Kidney Disease Task Force and Health and Safety Code, ch. 98 on September 1, 2009.

The bill would take immediate effect if finally passed by a two-thirds record vote of the membership of each house. Otherwise, it would take effect September 1, 2007.

SUPPORTERS SAY:

CSHB 1373 would help Texas better manage and prevent chronic kidney disease. If left untreated, damage to the filtering capabilities of the kidney can leave it so impaired that the patient must be placed on dialysis or require a transplant. Treatment at later stages is very expensive, and chronic kidney disease accounts for $18 billion of annual Medicare spending. In addition, for the 5 percent of chronic kidney disease patients not covered by Medicare, the state must pay for all the expenses involved in disease management, such as dialysis or transplantation.

Prevention can be a cost-effective way to improve patients' health, yet most people do not know how to prevent the onset of kidney failure, such as improved diet, inexpensive blood and urine screenings, and monitoring blood pressure. The bill would mobilize a task force to give serious thought to what the state could do to educate health care providers and individuals alike about the seriousness of chronic kidney disease and take steps to prevent it. The ultimate goal of the task force would be to reduce mortality and cost by devising a way to deal with the disease before the onset of renal failure.

This bill would create a multi-faceted task force with defined goals. In 2005, the 79th legislature enacted CSHB 1252 by Guillen, which required the addition of chronic kidney disease to the list of conditions for which Medicaid recipients could receive disease management services. This commitment to treating and preventing chronic kidney disease would be strengthened through the creation of a task force including physicians and experts in the diagnosis and treatment of chronic kidney disease, state legislators, DSHS, patient advocacy groups, health insurance providers, clinical laboratories, and renal care providers. The expertise of this diverse membership would facilitate an action-oriented approach by considering not only medical, advocacy, and educational perspectives but, unlike existing health councils, also including legislators whose public policy and appropriations expertise would help to formulate a statewide plan that actually could be implemented.

The model for this task force has been used in five other states, and is currently being considered in two others this year. The task force would not simply study the disease, but would institute an aggressive timeline for creating a plan of action for effective screening and early detection. Additionally, the task force would not duplicate the efforts of other health councils, such as the Texas Diabetes Council or the Texas Council on Cardiovascular Disease and Stroke. While those groups do include kidney disease among their educational efforts, it usually is addressed as an outcome of another illness, such as diabetes or hypertension, and not addressed as a health concern on its own.

CSHB 1373 would create a task force that is necessary for instituting best practices in chronic kidney disease prevention. The National Kidney Foundation has been instrumental in propagating clinical practice guidelines that have revolutionized early-stage kidney disease detection. As members of the task force, they would help ensure these detection methods were instituted statewide by primary care physicians and taught in medical schools. With the Texas border region experiencing some of the highest levels of kidney disease in the nation and the number of Texans with end-stage kidney disease increasing from 3,801 in 1980 to 37,386 in 2004, it is imperative to build public awareness on how to prevent kidney disease in a fashion that is similar to the public awareness about preventing heart attack or stroke.

Concerns about the cost of this bill are unfounded. According to the Legislative Budget Board, CSHB 1373 would have no significant fiscal

implication to the state and provides no basis for the appropriation of state funds in fiscal 2008-09. Any administrative costs would be absorbed within DSHS's existing budget. Further, the bill would authorize the task force to accept grants, gifts, and local or federal funds, none of which would affect state revenue.

OPPONENTS SAY:

The Chronic Kidney Disease Task Force would duplicate existing efforts to prevent kidney disease. The Texas Diabetes Council, established in 1983, and the Texas Council on Cardiovascular Disease and Stroke, established in 1999, already work on a statewide plan for prevention and education of diseases, including chronic kidney disease. Because major contributing factors to kidney disease are diabetes, hypertension, and obesity, there are significant overlaps between the goals of these councils and the proposed task force the Legislature would create. The work of the kidney disease task force just as easily could be handled by a subcommittee of professionals serving on the Texas Diabetes Council and the Texas Council on Cardiovascular Disease and Stroke. Instead of creating a new task force, the Legislature should focus on making existing programs focus new or additional resources on kidney disease.

This bill would create a task force that is not clearly defined and has an unrealistic outcome goal. While the task force as proposed would define the membership, the date the group would present its findings, and the date for abolishing the group, it does not include other practical information such as how the task force would function. This bill does not address how often the group would meet or define subcommittees for creating a report of its findings. Getting a task force of 17 members up and running would take a considerable amount of time, especially considering that appointments to the task force likely would not begin until the end of the legislative session in June. While the task force is designed to take action quickly, it would have less than 18 months of time available to meet, a timeline that might be too aggressive to produce useful work.

This bill could create additional costs for the state. While this task force would not receive an appropriation, it would consume administrative resources at DSHS. Because the task force would only function for two years, it would be impractical to hire additional staff members who would be unnecessary shortly thereafter. Instead, existing administrative staff would take on additional work of this new task force, in planning meetings, handling check requisitions, and producing the final report for the Legislature. It is possible that costs associated with this task force

would come at the expense of other chronic disease task forces and councils administered by the state.

NOTES:

The committee substitute differs from the original by adding the following four task force members: one representative from the National Kidney Foundation, one pediatrician in private practice, one kidney transplant surgeon, and one representative from the Texas Renal Coalition. The substitute also would allow DSHS to determine if reimbursements should be made to individual task force members.