

# Kidney Health Care

2004  
Annual  
Report



**Eduardo J. Sanchez, M.D., M.P.H.**  
Commissioner



## TEXAS DEPARTMENT OF STATE HEALTH SERVICES

EDUARDO J. SANCHEZ, M.D., M.P.H.  
COMMISSIONER

1100 W. 49<sup>th</sup> Street • Austin, Texas 78756  
1-888-963-7111 • <http://www.dshs.state.tx.us>

April 11, 2005

This report is submitted in accordance with the Kidney Health Care Act, Texas Health and Safety Code, Chapter 42, which requires the provision of an annual report to the Governor and Legislature on the activities of the Kidney Health Care (KHC) Program. This program is administered by the Texas Department of State Health Services.

This report covers the activities, expenditures, and accomplishments of KHC for the fiscal year ending August 31, 2004. Further, this report includes information on program activities and the fiscal impact of recipient growth. It describes KHC approved applicants, their primary diagnoses, and the treatment status of current KHC recipients. Demographic characteristics of the end-stage renal disease population served by KHC are described, along with a section on incidence, prevalence, mortality, and facility information.

KHC has provided services to Texans diagnosed with end-stage renal disease since September 1973. During these 31 years, more than 80,000 individuals diagnosed with this chronic disease have been approved for program benefits. KHC provides benefits for access surgery, dialysis treatments, hospitalization, medication, and transportation services.

As we begin our 32<sup>nd</sup> year of operations, KHC continues its commitment to providing quality customer service to Texans diagnosed with end-stage renal disease. For more information about the program, please contact Susan Ristine, Information Specialist, Purchased Health Services Unit, at 512-458-7160 or toll-free 1-800-222-3986, or email at [Susan.Ristine@dshs.state.tx.us](mailto:Susan.Ristine@dshs.state.tx.us).

Sincerely,

A handwritten signature in black ink, appearing to read "EJ Sanchez M.D.", written over a horizontal line.

Eduardo J. Sanchez, M.D., M.P.H.  
Commissioner

# **KIDNEY HEALTH CARE PROGRAM 2004 ANNUAL REPORT**

## **DIVISION FOR FAMILY AND COMMUNITY HEALTH SERVICES**



**1100 WEST 49<sup>TH</sup> STREET  
AUSTIN, TEXAS 78756**



DEPARTMENT OF STATE HEALTH SERVICES

Eduardo J. Sanchez, M.D., M.P.H.  
Commissioner

David Wanser, Ph.D.  
Deputy Commissioner for Behavioral and Community Health Services

Evelyn Delgado, B.S.  
Assistant Commissioner for Family and Community Health Services

Randy Fritz, M.P.A.  
Chief Operating Officer

Machelle Pharr, CPA, C.G.F.M.  
Chief Financial Officer

## **Contributors**

### **Fiscal Year 2004 Annual Report**

Susan Ristine, MSHP  
Lisa Rodriguez, M.Ed.

Judith Permenter  
Rhonda Jones, B.A.

Scott Arnold

The data presented in this report were compiled and tabulated by the Adult Customer Services Group of the Kidney Health Care Program in the Purchased Health Services Unit. The statistical data were provided by the Family and Community Health Support Branch, Information Technology Application Development Unit. The state population figures were provided by the Texas A&M University State Data Center, accessed through EPIGRAM Data Analysis Software. The printing and binding of this report were provided by Health and Human Services Printing Services. The Department of State Health Services Art Department provided design services.

## **Availability of Additional Data**

This publication includes data most frequently requested by individuals interested in ESRD information. More detailed demographics and data other than that which is included in this report are available but may require cost reimbursement for staff and computer time. This report is available at <http://www.dshs.state.tx.us/kidney/default.shtm>. All requests for additional data or reports should be sent to:

Mail Code: 1938    Department ID: G31000  
Kidney Health Care Program  
Adult Customer Services Group  
Purchased Health Services Unit  
Department of State Health Services  
1100 W. 49th Street  
Austin, TX 78756  
(512) 458-7150  
Fax (512) 458-7162

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**OBTAINING ADDITIONAL INFORMATION**

**KIDNEY HEALTH CARE FORMS**



# **Program and Fiscal Information**

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# Program & Fiscal Information

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## Legislative Authority

The Kidney Health Care Act (Article 4477-20, Vernon's Texas Civil Statutes) authorized the establishment of the Kidney Health Care (KHC) Program in April 1973 under the Texas Department of Health, now the Department of State Health Services (DSHS). The program was later recodified under Texas Health and Safety Code, Chapter 42. This law directs the use of State funds and resources for the care and treatment of persons suffering from end-stage (chronic) renal disease. In doing so, the Legislature recognized the State's "responsibility to allow its citizens to remain healthy without being pauperized . . ." by the extremely expensive treatment which is necessary for those suffering from this disease. This annual report is submitted in compliance with the Texas Health and Safety Code, Chapter 42, Section 16.

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## History

End-Stage Renal Disease (ESRD), or chronic kidney failure, is the stage of permanent and irreversible kidney disease that requires the use of renal replacement therapy (kidney dialysis or transplantation) to maintain life. ESRD is usually the result of years of chronic kidney disease caused by inherited conditions, medical conditions such as diabetes and/or hypertension, or an injury to the kidneys. ESRD is the final stage of a slow deterioration of the kidneys, a process known as nephropathy.

Prior to 1973, persons suffering from ESRD had very few options available to them to treat this disease. Death was the most common outcome because few patients could afford the tremendous expense associated with renal replacement therapy.

In 1973, Congress created the Chronic Renal Disease (CRD) Program under Medicare to assist ESRD patients with the financial burden associated with this disease. Under the CRD Program, Medicare covers allowable medical costs for dialysis and transplant patients who are fully or currently insured under Social Security. This has made treatment more accessible and has increased the number of ESRD patients receiving therapy. Today, more than 300,000 patients are receiving ESRD therapy nationally - more than **30,000** of whom are Texas patients.

Despite the Medicare CRD Program, the impact and cost of ESRD on Texans is great. Most dialysis patients do not receive any medical benefits from Medicare for a three-month period after the initiation of dialysis, and Medicare does not offer coverage for most drug and travel expenses associated with the treatment of ESRD, with the exception of immunosuppressive drugs for certain Medicare-eligible transplant patients. To help ease the financial burden on people suffering from ESRD, the Texas Legislature created the Kidney Health Care (KHC) Program. The primary purpose of KHC is to "direct the use of resources and to coordinate the efforts of the State in this vital matter of public health."

The KHC Program has grown from 819 approved applicants in FY74 to 24,239 eligible recipients in FY04. During these 31 years, nearly 80,000 KHC recipients have been approved to receive financial assistance for access surgery, dialysis treatments, hospitalization, medication, and transportation costs incurred in the treatment of ESRD.

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### Fiscal Year 2004 Accomplishments

During Fiscal Year 2004, the Kidney Health Care Program successfully met the following program goals:

- ◆ Provided training to 85 KHC dialysis facilities and 79 participants on the Automated System for Kidney Information Tracking (ASKIT) web-system.
- ◆ Provided information and educational programs to the public on kidney disease and organ donation/transplantation.
- ◆ Provided program analyses and planning for consolidation activities mandated by House Bill 2292, 78th Texas Legislature, Regular Session.
- ◆ Administered grant awards for organ donor awareness and education programs for the Anatomical Gift Educational Program (AGEP).
- ◆ Began the analysis of the impact of the Medicare Improvement and Modernization Act of 2003 (Medicare Part D) on the KHC Program.
- ◆ Re-enrolled KHC providers using the KHC provider agreement.
- ◆ Finalized and adopted new KHC rules, implementing the eligibility criteria that Medicaid eligibles with full Medicaid benefits are no longer eligible for the KHC program.
- ◆ Began the analysis and planning of the integration and consolidation of administrative functions for the KHC and Children with Special Health Care Needs Services (CSHCN) Programs. Note: The KHC and CSHCN Programs became the Purchased Health Services Unit of the Department of State Health Services on September 1, 2004.

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### Fiscal Year 2005 Program Goals

Consistent with the program's efforts to maintain continuous quality improvements, the following goals were developed for Fiscal Year 2005:

- ◆ Promote organ donor education through the AGEP, including awarding funds to education providers, implementing a State Employee Organ Donor Awareness Campaign, and providing information and resources on the laws and procedures related to organ donation to attorneys and medical and nursing schools.
- ◆ Provide transition planning for the transfer of transportation services from KHC and the Health and Human Services Commission (HHSC) to the Texas Department of Transportation (TxDOT), as mandated by House Bill 2292.
- ◆ Promote and encourage the use of Medicare Discount Drug Cards and Transitional Assistance to program recipients and social workers.
- ◆ Analyze and develop program plans for the implementation of Medicare Part D benefits.
- ◆ Develop program rules, policies, and procedures to coordinate KHC benefits and Medicare Part D drug benefits.
- ◆ Promote, educate, coordinate, and assist KHC Medicare beneficiaries in enrolling in Part D plans through direct and contracted education efforts.
- ◆ Complete the functional integration of the KHC and CSHCN Programs.

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## Program Eligibility

An applicant must meet all of the following requirements to receive Kidney Health Care benefits:

- ◆ Have a diagnosis of ESRD;
- ◆ Be a resident of the State of Texas and provide documentation of Texas residency;
- ◆ Submit an application for benefits through a participating facility;
- ◆ Be receiving a regular course of chronic renal dialysis treatments or have received a kidney transplant;
- ◆ Meet the Medicare criteria for ESRD;
- ◆ Per KHC rule change effective July 2004, be ineligible for full Medicaid benefits; and
- ◆ Per KHC rule change effective July 2004, have a gross income of less than \$60,000 per year.

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## Fiscal Year 2004 Benefits

Specific program benefits are dependent on the applicant's treatment status and eligibility for benefits from other programs such as Medicare, Medicaid, or private insurance. KHC benefits are subject to budget limitations and to the reimbursement rates established by the DSHS. Specific benefits include payment for allowable drugs, transportation, and medical expenses incurred as a direct result of ESRD treatment.

### Drugs

This benefit is available to all recipients, except recipients who are eligible for drug coverage under

a private/group health insurance plan, or to those receiving full Medicaid prescription drug benefits. Reimbursement is limited to four prescriptions per month for recipients. Reimbursement is also limited to KHC allowable drugs. The KHC program recommends, and the Assistant Commissioner for Family and Community Health Services approves which drugs are covered by the program. All KHC recipients are required to obtain their medications from a KHC participating pharmacy. In FY04, 12,299 program recipients received a drug benefit from KHC, for an average cost per recipient of \$1,142 per year.\*

### Transportation

Recipients eligible for travel benefits are reimbursed at 13 cents per round-trip mile, based on the recipient's treatment status and the number of allowable trips taken per month to receive ESRD treatment. Reimbursement is limited to a \$200 monthly maximum. Recipients who are eligible for transportation benefits under the Medicaid Medical Transportation Program are not eligible to receive KHC transportation benefits. In FY04, 15,385 program recipients received a travel benefit from KHC, for an average cost per recipient of \$269 per year.\* As a result of House Bill 2292, on September 1, 2003, all DSHS transportation services were transferred to TxDOT. Currently, KHC is continuing to process travel claims for this benefit under an HHSC Interagency Agreement with TxDOT.

### Medical

KHC provides limited payment for ESRD-related medical services. Allowable services include inpatient and outpatient dialysis treatments and medical services required for access surgery, which include hospital, surgeon, and anesthesiology charges.

\* Data as of 11/05/04, ASKIT.

Access Surgery. Access surgery is a procedure necessary for the initiation of dialysis treatments. Charges for hospitalization, surgeon and assistant surgeon fees, as well as anesthesiologist fees are covered. Because this surgery is typically done before the patient qualifies for ESRD benefits through Medicare, this benefit can be covered retroactively, up to 180 days before the date of KHC eligibility. Reimbursement is limited to \$4,100 for each in-patient access surgery.

In FY04, 775 program recipients received a medical benefit from KHC, for an average cost per recipient of \$2,081 per year.\*

### **Medicare Premium Payment**

KHC will pay the premium for Medicare parts A and B on behalf of KHC recipients who are: 1) eligible to purchase this coverage according to Medicare's criteria; 2) not eligible for "premium free" Medicare part A (hospital) insurance under the Social Security Administration; and 3) not eligible for Medicaid payment of Medicare premiums.

\* Data as of 11/05/04, ASKIT.

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### **The following limitations apply to KHC benefits:**

- ◆ KHC is the payor of last resort. All third parties must be billed prior to KHC.
- ◆ Claims must be received by KHC by the applicable filing deadlines.
- ◆ KHC benefits are limited to recipients whose gross income is less than \$60,000 per year.

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## **Fiscal Year 2004 Recipient Income**

Table 1 reports the income of FY04 program recipients. In July 2004, KHC began using gross income versus adjusted gross income as the income eligibility criteria per a KHC rule change. Table 1 data therefore includes both the adjusted gross and gross income of KHC recipients. As in previous years, the largest percentage of recipients (77.4%) are those with an income of less than \$20,000 annually.

**Table 1: FY04 Recipient Income\***

<b>Income</b>	<b># Recipients</b>	<b>% Recipients</b>
\$0-19,999	18,757	77.4%
\$20,000-29,999	2,749	11.3%
\$30,000-39,999	1,525	6.3%
\$40,000-44,999	467	1.9%
\$45,000-49,999	327	1.3%
\$50,000-54,999	256	1.1%
\$55,000-59,999	158	0.7%
	24,239	100%

\*As of 8/31/04, ASKIT.

## Fiscal Year 2004 Client Services Expenditures

Client services expenditures by program benefit provided to KHC recipients are reported in Table 2 below. Expenditures for drugs used in the treatment of ESRD continue to account for the largest expenditure, comprising \$14 million, or 71% of total FY04 client services expenditures. Of the remaining FY04 client services expenditures, travel accounted for 21% and medical services accounted for 8%.

The current KHC Reimbursable Drug List includes 38 therapeutic categories of medications. In FY04, the top five drug expenditures by

therapeutic category were (1) immunosuppressants, (2) phosphate binders, (3) cardiovascular/antihypertensive drugs, (4) hypoglycemic (insulin) agents, and (5) antihyperlipidemics.

The total number of FY04 drug claims was 249,157 for a total drug expenditure of \$14 million. This represented an average cost per drug claim of \$56.35.

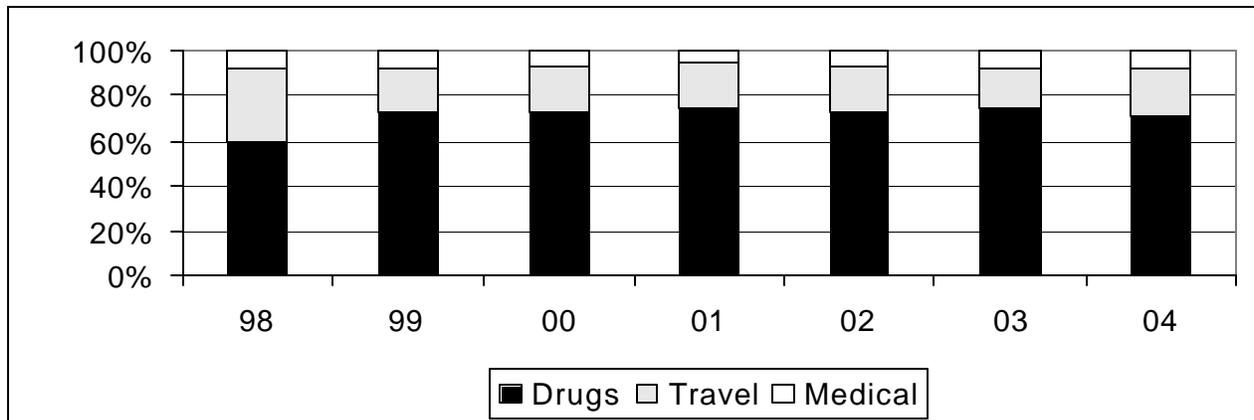
In 1999, the Texas Legislature required KHC to develop a voluntary drug manufacturer rebate program. Presently, 181 manufacturers have a rebate agreement with KHC. Rebates collected in FY04 totaled \$1.9 million.

**Table 2: Fiscal Year 2004 Client Services Expenditures**

Client Services		Expenditures
	Drugs	\$ 14,042,110
	*Travel	4,146,120
	Medical	1,612,400
<b>Total</b>		<b>\$ 19,800,630</b>

\* Texas Department of Transportation funds.

**Figure 1: Client Services Expenditures, FY98-FY04**



Expenditures as of 11/05/04, ASKIT. These numbers may vary for up to a year due to the 95-day claim filing deadline, reconciliation of claims, and claims adjustments for appeals.

**Client Services Expenditures and Unduplicated Recipients**

“Unduplicated recipients” are recipients who used a KHC benefit in the fiscal year being reported. Table 3 below and Figure 2 on page 7 provide a historical view of the ESRD population served by KHC and compares that growth to the total budget for KHC and the amount expended on client services. Client services expenditures include the total amount expended on drug, travel, and medical reimbursements provided to KHC recipients during the fiscal year being reported.

In FY85, KHC expended \$15 million to provide services to 5,774 unduplicated recipients, for an average yearly expenditure per recipient of \$2,602, whereas in FY04, KHC expended \$19.8 million to provide services to 18,407 unduplicated recipients, for an average expenditure per recipient of \$1,076.

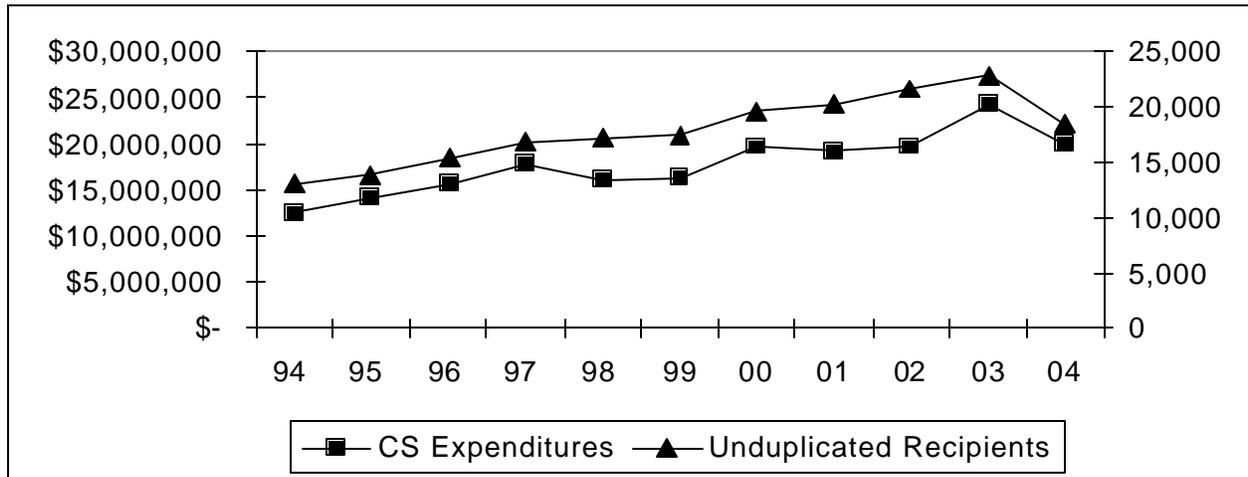
As seen in Table 3, KHC served almost 6,000 unduplicated recipients in FY85, while in the mid 1990s, that number exceeded 13,000. In FY04, the number of unduplicated recipients increased to 18,407. Since 1985, client services expenditures have increased by 32%, while the number of unduplicated recipients served increased by 219%. KHC is projecting a 5% increase in the number of recipients to be served in FY05.

**Table 3: Client Services Expenditures and Unduplicated Recipients**

Fiscal Year	KHC Total Budget	Client Services Expenditures	# Unduplicated Recipients	Expenditure per Recipient
85	\$ 15,737,248	\$ 15,022,623	5,774	\$ 2,602
86	9,548,438	8,997,391	6,377	1,411
87	9,969,953	9,436,721	7,044	1,340
88	9,973,442	9,300,774	7,987	1,164
89	9,986,208	9,374,638	9,034	1,038
90	11,321,450	10,631,499	10,016	1,061
91	12,349,838	11,608,723	10,928	1,062
92	13,165,309	12,251,598	11,966	1,024
93	13,055,598	12,022,519	12,547	958
94	13,588,910	12,561,567	12,964	969
95	15,353,705	14,104,412	13,726	1,028
96	17,240,127	15,688,022	15,442	1,016
97	18,940,127	17,758,278	16,737	1,061
98	18,240,127	16,159,865	17,270	936
99	18,850,152	16,400,628	17,456	940
00	20,408,274	19,748,957	19,553	1,010
01	20,477,876	19,102,669	20,170	947
02	22,280,505	21,792,983	21,602	1,009
03	26,560,106	24,321,630	22,833	1,065
04*	22,097,059	19,800,630	18,407	1,076

\*Expenditures as of 11/5/04, ASKIT. These numbers may vary for up to a year due to the 95-day claim filing deadline, reconciliation of claims, and claims adjustments for appeals. No adjustments are made to prior year data.

Figure 2: Program Growth, FY94-FY04



### Client Services Expenditures by Primary Diagnosis

Table 4 reports client services expenditures by primary diagnosis for FY04 recipients. As in previous years, KHC recipients with a primary

diagnosis of diabetes comprised the largest portion of client services expenditures (\$8.5 million). Of the remaining FY04 client services expenditures, recipients with a primary diagnosis of hypertension and glomerulonephritis comprised the second and third largest expenditure, at \$4.9 million and \$3.1 million, respectively.

Table 4: FY04 Client Services Expenditures by Primary Diagnosis

Primary Diagnosis	Client Services Expenditures	% Total Expenditures	# Unduplicated Recipients	Average Per Recipient
Diabetes	\$ 8,544,908	43.2%	8,753	\$ 976
Hypertension	4,861,995	24.6%	4,681	1,039
Glomerulonephritis	3,079,675	15.6%	2,276	1,353
Congenital Anomalies	798,050	4.0%	620	1,287
Connective Tissue Disease	393,600	2.0%	356	1,106
Blood Diseases	15,653	0.1%	25	626
HIV/AIDS	66,883	0.3%	65	1,029
Urinary System Disease	738,393	3.7%	746	990
Metabolic Diseases	46,092	0.2%	63	732
Malignant Neoplasm	110,383	0.6%	134	824
Unknown Etiology	849,290	4.3%	278	3,055
Other	295,708	1.4%	657	450

Expenditures as of 11/05/04, ASKIT. These numbers may vary for up to a year due to the 95-day claim filing deadline, reconciliation of claims, and claims adjustments for appeals.

## Kidney Health Care

There are various factors that influence the costs for KHC recipients according to primary diagnosis, including the number of drugs prescribed, the costs of medications associated with certain primary

diagnoses and treatment modality, and the number and severity of co-morbid conditions within the patient population.

### Client Services Expenditures by Treatment Status

account for the highest expenditure of \$13 million, or 66% of the FY04 client services budget.

Table 5 reports the distribution of client services expenditures by treatment status and includes the percent of total expenditures, the number of unduplicated recipients, and the average expenditure per recipient for FY04. While considerable variation exists in spending among treatment modalities, recipients using in-center hemodialysis

**Table 5: FY04 Client Services Expenditures by Treatment Status**

	Treatment Status	Client Services Expenditures	% Total Expenditures	# Unduplicated Recipients	Average per Recipient
In-Center	Hemodialysis	\$ 13,081,287	66.1%	15,104	\$ 866
	Peritoneal Dialysis	3,435	0.0%	13	264
	Self Hemodialysis	5,390	0.0%	5	1,078
In-Home	Continuous Ambulatory Peritoneal Dialysis	550,493	2.8%	683	806
	Continuous Cycling Peritoneal Dialysis	395,422	2.0%	451	877
	Hemodialysis	6,179	0.0%	12	515
Transplant	Living Donor	1,167,979	5.9%	607	1,924
	Cadaveric	4,590,445	23.2%	2,309	1,988

*Expenditures as of 11/05/04, ASKIT. These numbers may vary for up to a year due to the 95-day claim filing deadline, reconciliation of claims, and claims adjustments for appeals.*

## Client Services Expenditures by Age Group

Table 6 reports the distribution of client services expenditures by age group and includes the percentage of total expenditures, the number of unduplicated recipients, and the average expenditure per recipient for FY04.

Among all age groups, the largest amount expended in FY04 was for recipients in the 55-64 age group (\$5.0 million). The amount expended on recipients in the 45-54 age group followed closely at \$4.8 million. Together, these two age groups comprised nearly one-half (49.6%) of FY04 client services expenditures.

**Table 6: FY04 Client Services Expenditures by Age Group**

Age Group	Client Services Expenditures	% Total Expenditures	# Unduplicated Recipients	Average per Recipient
0-20	\$ 67,749	0.3%	57	\$ 1,189
21-34	1,691,164	8.6%	1,183	1,430
35-44	3,104,563	15.7%	2,370	1,310
45-54	4,842,584	24.5%	4,205	1,152
55-64	4,977,075	25.1%	4,957	1,004
65-74	3,530,365	17.8%	4,314	818
75+	1,587,130	8.0%	2,493	637

*Expenditures as of 11/05/04, ASKIT. These numbers may vary for up to a year due to the 95-day claim filing deadline, reconciliation of claims, and claims adjustments for appeals.*

# Approved Applicants

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# Approved Applicants

In this section we present information on the age, gender, and ethnic profiles of KHC approved applicants and currently eligible recipients. **Approved Applicants** are the number of people with ESRD who became newly eligible for KHC benefits during the fiscal year being reported. **Currently Eligible(s)** are the total number of program recipients who are eligible to receive KHC benefits at some point during the fiscal year being reported.

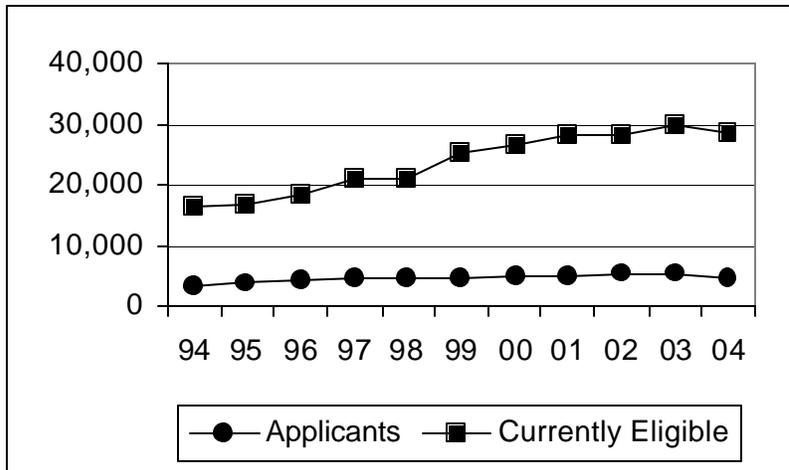
fact, the number of currently eligible recipients has increased by 86% over the 10-year period being reported.

Figure 4 illustrates the status of applicants by fiscal year of entry into the program. While the program has seen an increase in applicants over the years, in FY04 a decrease in applicants and eligible program recipients occurred due to changes in program rules (see Table 7, page 12).

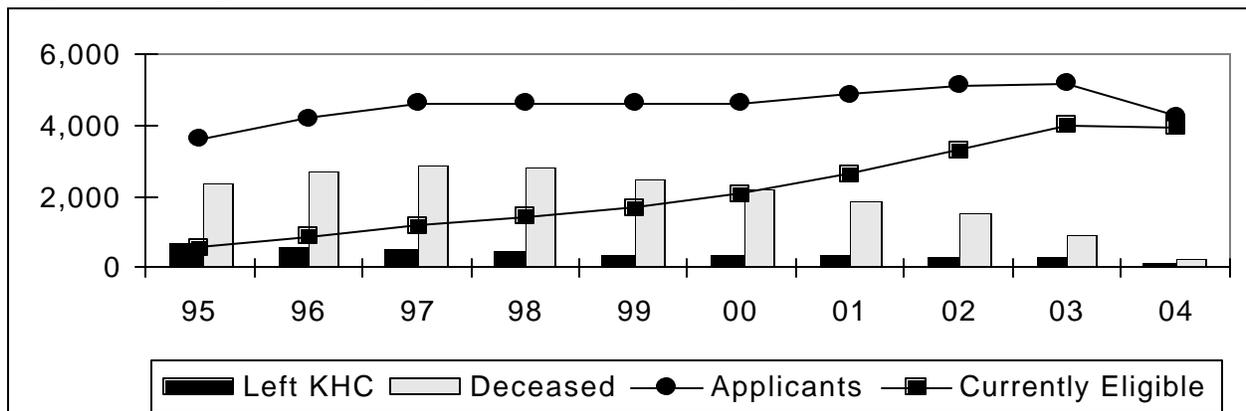
Figure 3 shows the number of approved applicants and currently eligible recipients at the end of each fiscal year since FY94. While the number of approved applicants has steadily increased over the years, in FY04, the program experienced a decrease of 1,026 applicants from the prior fiscal year. This is due to the discontinuation of drug benefits to the KHC Medicaid-eligible population.

While FY04 experienced a decrease in the number of approved applicants, the steady growth in the number of eligible recipients over the years cannot be overlooked -- in

**Figure 3: Program Growth of Approved Applicants and Currently Eligible**



**Figure 4: Program Status by Fiscal Year of Entry**



**Table 7: Approved Applicants by Fiscal Year of Entry (FY74-FY04)**

<b>Fiscal Year of Entry</b>	<b>Approved Applicants<sup>1</sup></b>	<b>Annual % of Change</b>	<b>Currently Eligible in FY04<sup>2</sup></b>	<b>Left KHC before 8/31/04<sup>3</sup></b>	<b>Reported Deaths as of 8/31/04<sup>4</sup></b>
74-94	34,183	--	2,536	3,384	28,263
95	3,622	--	592	668	2,362
96	4,162	14.9	870	585	2,707
97	4,617	10.9	1,199	522	2,896
98	4,650	0.7	1,441	422	2,787
99	4,627	-0.5	1,718	398	2,511
00	4,634	0.2	2,069	368	2,197
01	4,860	4.9	2,596	366	1,898
02	5,137	5.7	3,317	337	1,483
03	5,217	1.6	3,994	287	936
04	4,323	-20.6	3,862	222	239
<b>Total</b>	<b>80,032</b>	<b>--</b>	<b>24,194</b>	<b>7,559</b>	<b>48,279</b>

**Table 7 Notes**

<sup>1</sup> The methodology used to calculate approved applicants in prior Fiscal Years was based on the patient's year of initial entry into the program. As of Fiscal Year 2000, this number is now calculated based on the patient's most recent year of re-entry into the program.

<sup>2</sup> Currently eligible includes those applicants by Fiscal Year who were eligible to receive benefits at some point during FY04. Prior to FY99, the applicant's status was denoted as "Active" or "Inactive".

<sup>3</sup> Left KHC status includes all applicants who left the program for various reasons other than reported death (e.g. moved out of state, stopped dialysis, regained function).

<sup>4</sup> The actual number of deaths may be greater than the number of deaths reported as the status of patients who are not actively participating in KHC is unknown.

Note: These numbers change continuously and are only indicative for FY04, as of 8/31/04.

Table 8: Approved Applicant Profile, FY94 &amp; FY04

Age Group	FY94 Approved Applicants		FY04 Approved Applicants		Projected 2004 Texas Population	
	Total	% of Total	Total	% of Total	Total	% of Total
0-20	67	1.90	40	0.93	7,094,450	32.02
21-34	327	9.28	307	7.10	4,637,672	20.93
35-44	436	12.37	493	11.40	3,329,756	15.03
45-54	615	17.45	955	22.09	2,962,828	13.37
55-64	837	23.75	1,110	25.68	1,940,510	8.76
65-74	831	23.58	870	20.12	1,194,624	5.39
75+	411	11.67	548	12.68	998,286	4.50
<b>Totals</b>	<b>3,524</b>	<b>100.00</b>	<b>4,323</b>	<b>100.00</b>	<b>22,158,126</b>	<b>100.00</b>
<b>Gender</b>						
Female	1,713	48.61	1,913	44.25	11,122,060	50.19
Male	1,811	51.39	2,410	55.75	11,036,066	49.81
<b>Totals</b>	<b>3,524</b>	<b>100.00</b>	<b>4,323</b>	<b>100.00</b>	<b>22,158,126</b>	<b>100.00</b>
<b>Ethnicity</b>						
African American	925	26.25	1,145	26.49	2,548,851	11.50
Hispanic	1,257	35.67	1,778	41.13	7,553,619	34.09
White	1,274	36.15	1,290	29.84	11,267,243	50.85
Other	68	1.93	110	2.54	788,413	3.56
<b>Totals</b>	<b>3,524</b>	<b>100.00</b>	<b>4,323</b>	<b>100.00</b>	<b>22,158,126</b>	<b>100.00</b>

This table reflects the age, gender, and ethnic distribution of KHC applicants. The age distribution of FY04 applicants shows that the greatest percentage of approved applicants fall into the 45-54 and 55-64 age groups. In FY94, the greatest percentage of approved applicants was in the 55-64 and 65-75 age categories.

The median age of KHC applicants in FY04 was 58 and the average age was 57. In FY94, the median age was 59 and the average age was 56. Nationally, the median age at which patients begin ESRD treatment is 64 (United States Renal Data System 2004 Annual Data Report).

With regard to gender, the number of male approved applicants continues to remain higher than that of females.

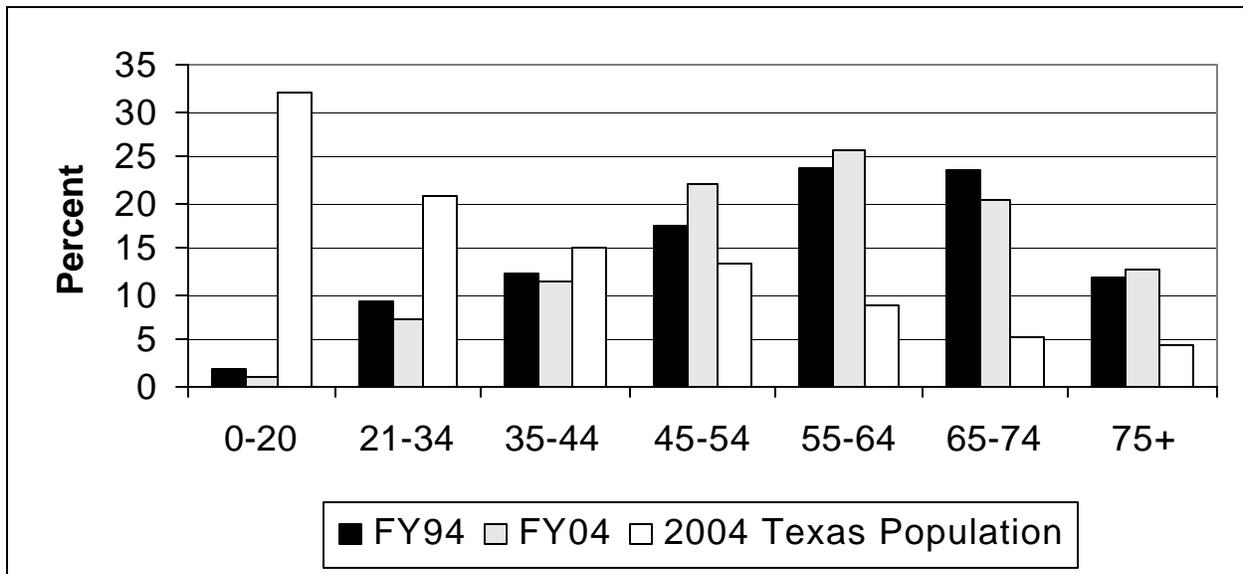
Most notable within the ethnic distribution of FY04 program applicants is the high percentage of Hispanic applicants. In FY04, the Hispanic group comprised 41% of all approved applicants. The growth of patients within the KHC Hispanic population continues to be more dramatic than among patients within any other race or ethnicity.

Note: The "Other" ethnic category includes Indian, Asian, American Indian/Alaskan Native, Pacific Islander, and Mid East/Arabian applicants.

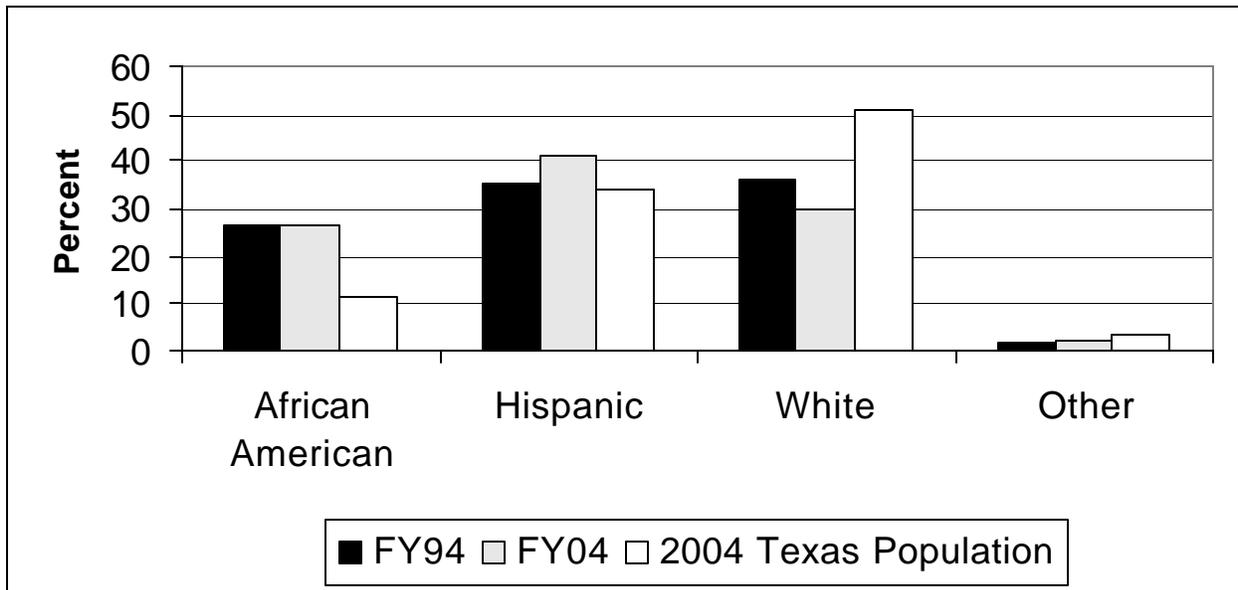
**Age Group** - In FY95, KHC realigned the age groups to be consistent with Medicare and the United States Renal Data System (USRDS) categories to allow comparative analysis of changes among applicants age 65 and older.

**Population** - State population figures are obtained from the Texas A&M State Data Center and are based on unadjusted 2000 census figures.

**Figure 5: Percentage of Approved Applicants by Age Group, FY94 & FY04**



**Figure 6: Percentage of Approved Applicants by Ethnic Group, FY94 & FY04**



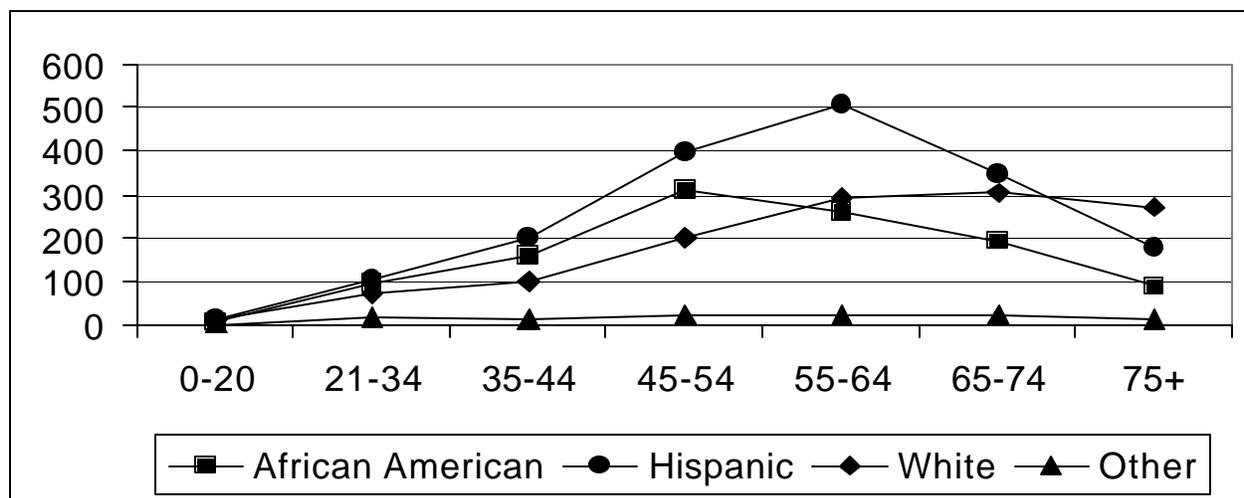
**Figure 7: Approved Dialytic Applicants by Age Group & Ethnicity, FY04\***

Figure 7 shows the number of FY04 approved dialytic applicants (hemodialysis, continuous ambulatory peritoneal dialysis, and continuous cycling peritoneal dialysis) by age group and ethnicity. As seen, trends are apparent within the Hispanic and African American groups regarding age group of entry into the KHC program.

group, the majority of Hispanic applicants entered the program in the 55-64 age group, while the majority of White applicants entered the program in the 65-74 age group. This suggests that larger numbers of KHC minority applicants are experiencing the onset of kidney failure earlier than White applicants (see mean and median ages below, Table 9).

For KHC, the majority of FY04 African American applicants entered the program in the 45-54 age

**Table 9: Approved Dialytic Applicants, Age Group by Ethnicity\***

Age	African American	Hispanic	White	Other
0-20	6	13	9	1
21-34	95	104	69	14
35-44	162	197	100	11
45-54	309	397	198	22
55-64	260	509	291	24
65-74	194	345	305	23
75+	90	177	272	9
Total	1,116	1,742	1,244	104
Mean	54	56	61	54
Median	54	58	63	56

\* Dialytic applicants only -- transplant patients are excluded from this data.

# Primary Diagnosis

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## Primary Diagnosis

The kidneys are two bean-shaped organs about the size of a fist, which are located in the middle of the back, one on each side of the spine just below the rib cage. Although the kidneys are small organs by weight, they receive 20–25% of the total arterial blood pumped by the heart. The large blood supply to the kidneys enables them to cleanse the blood by filtering out excess water and waste products and producing hormones that regulate blood pressure and keep bones strong. The kidneys also regulate the body's salt and potassium levels, stimulate the making of red blood cells, and maintain the body's calcium levels. This section presents information on the primary diagnoses and patient characteristics of the KHC *incident population*.\*

Kidney failure is divided into two classifications. **Acute kidney failure** is most likely to occur after infection, complicated surgery or a severe injury, or when blood vessels leading to the kidneys become blocked. In most cases, full kidney function can be restored. **Chronic, or permanent kidney failure**, also known as ESRD, usually develops slowly over a period of years, with few signs or symptoms in the early stages. ESRD is the clinical condition resulting from a number of pathologic processes that lead to diminished renal reserve or complete renal insufficiency (renal failure), and requires dialysis or transplantation to perform the functioning of the failed kidneys. Medical conditions and diseases, congenital malformations, and injuries can also render the kidneys incapable of performing their life-sustaining functions.

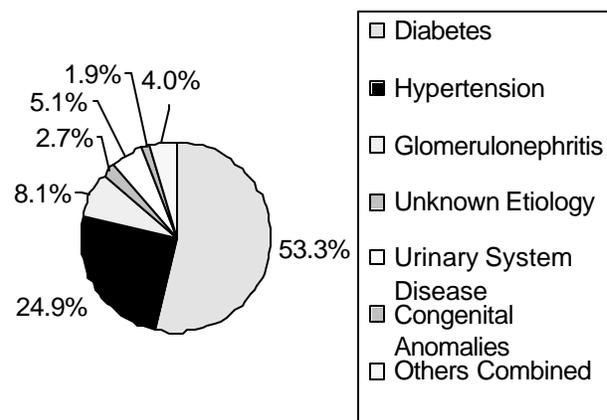
**Diabetes** is the most common cause of kidney failure, both in Texas and in the United States. Diabetes is a disease in which the pancreas does not produce enough insulin or cannot efficiently use the insulin that is produced. Insulin is a hormone that regulates the amount of glucose in the blood.

\*The KHC *incident population* refers to new applicants approved for program benefits during the fiscal year being reported.

Without insulin, the body is unable to convert glucose to energy, leaving large amounts of sugar in the blood stream, which can slowly damage the filtering membranes in the kidneys. A scar-like material builds up on the capillary walls of the glomeruli where filtering takes place, which impairs kidney function. Diabetes can also lead to other co-morbid conditions such as diabetic neuropathy (peripheral nerve damage) and cardiovascular disease, the latter being the predominant cause of death in patients with ESRD.

**Hypertension**, or high blood pressure, is the second leading cause of kidney failure, both in Texas and in the United States. Hypertension is a disease in which the constriction of blood vessels reduces the supply of blood to the kidneys, and over years, damages the working units (nephrons) of the kidneys. High blood pressure makes the heart work harder, and over time can damage the blood vessels throughout the body. When the blood vessels in the kidneys become damaged, they stop doing their job of removing wastes and extra fluid from the blood. The extra fluid may then raise blood pressure even more.

**Figure 8:**  
**Primary Diagnosis of FY04 Applicants**



**Glomerulonephritis**, the third leading cause of ESRD for KHC approved applicants, is a group of diseases caused by inflammation and destruction of the glomeruli, the blood filtering structures in the nephrons. *Acute glomerulonephritis* is characterized by a rapid loss of kidney function, and is usually the result of an immune response to a bacterial infection. Nephrologists can successfully treat this form of glomerulonephritis with antibiotic therapy.

*Chronic glomerulonephritis* is the advanced stage of a group of kidney disorders, and results in inflammation and a gradual, progressive destruction of the glomeruli. Some cases are caused by specific stimuli to the immune system, but the precise cause of most cases is unknown. Currently, there is no cure for this chronic form of glomerulonephritis.

Diabetes was the leading cause of ESRD for KHC approved applicants in FY04, comprising 53.3% of new cases (Figure 8). Ten years ago, applicants with this primary diagnosis made up 46.4% of new cases. Diabetes has been the most common cause of chronic renal failure in the KHC incident population since FY82.

In FY04, 25% of KHC approved applicants had a primary diagnosis of hypertension, a decrease of 4% from FY94. KHC has seen consistent patterns over the years of hypertension being the second

leading cause of renal failure in KHC approved applicants. Diabetes and hypertension are listed as the primary causes of ESRD in 78% of KHC incident patients.

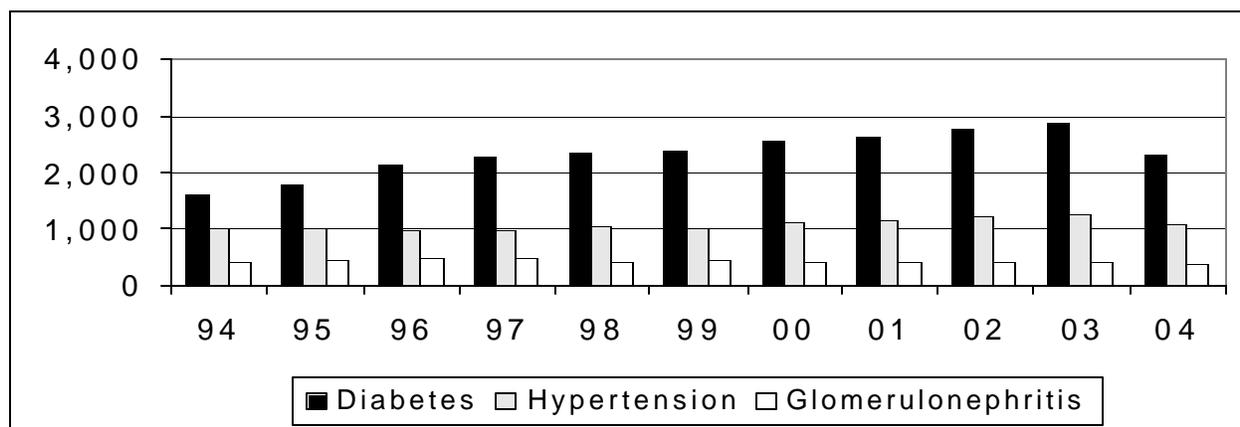
In FY04, 8.1% of the KHC incident population had a primary diagnosis of glomerulonephritis, a decrease of 4% from the percentage of FY94 applicants with this diagnosis.

After diabetes, hypertension, and glomerulonephritis, the most common primary diagnoses in FY04 were urinary system disease, unknown etiology, and congenital anomalies. Urinary system disease includes interstitial nephritis (a disease that affects the bladder), urinary tract infections, kidney stones, and other disorders of the urinary system. Congenital anomalies include cystic disorders of the kidney such as polycystic kidney disease, medullary cystic kidney disease, and other disorders such as renal calculi, Alport's syndrome, and tuberous sclerosis.

Figure 9 shows the leading primary diagnoses for KHC applicants between FY94 and FY04. Diabetes has remained the leading primary diagnosis for all years depicted.

For detailed information on primary diagnoses, please refer to the tables on page 20 in this section.

**Figure 9: Leading Primary Diagnoses FY94-FY04**



As of 10/05/04, ASKIT.

### Primary Diagnosis by Age

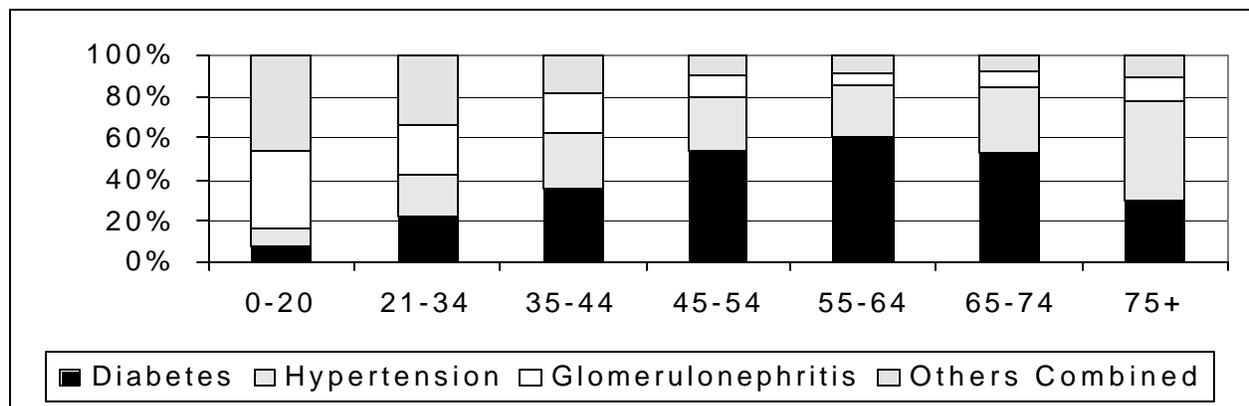
When looking at FY04 primary diagnosis by age, diabetes is the leading cause of ESRD among KHC applicants who are age 35 and over. Among applicants under the age of 21 at the time of entry into the program, glomerulonephritis was the most common cause of kidney failure. Hypertension was the leading cause of ESRD among applicants in the 21-34 age group.

In FY94, similar trends were seen with diabetes as the leading primary diagnosis for most age groups, with the exception of those applicants in the 0-21 and 21-34 age groups, in which glomerulonephritis was the leading primary diagnosis.

Figure 11 shows that KHC applicants in the 55-64 age group have the highest percent of ESRD due to diabetes, comprising 67% of cases within that age category.

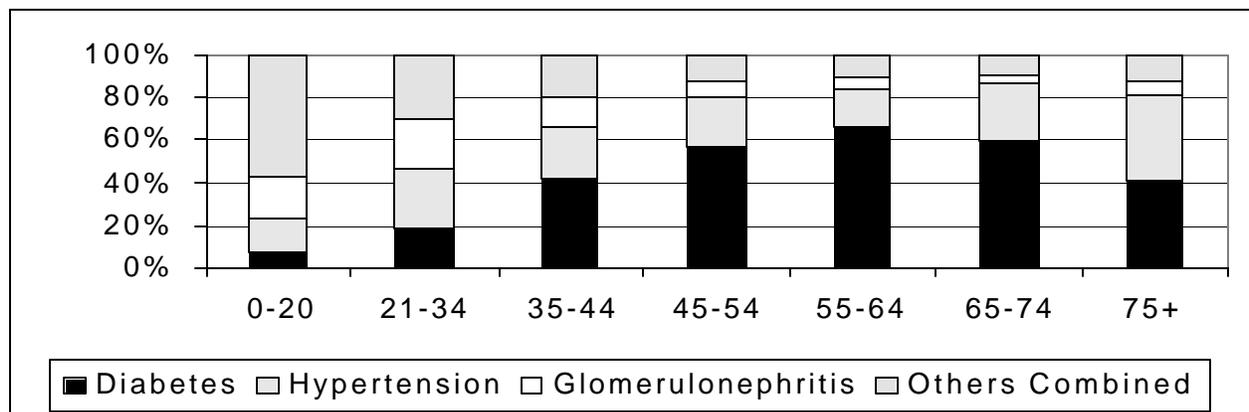
In FY04, hypertension comprised 25% of new applicants and was highest in applicants within the 75+ age group. It is important to note that in FY94, diabetes as a primary diagnosis comprised 30% of applicants within the 75+ age group -- hypertension comprised 48.4% of applicants within this group. In FY04, diabetes as a primary diagnosis comprised 40.3% of applicants within the 75+ age group, and applicants with hypertension comprised 40.7% of applicants in this same group.

**Figure 10: Primary Diagnosis by Age, FY94**



As of 10/05/04, ASKIT.

**Figure 11: Primary Diagnosis by Age, FY04**



As of 10/05/04, ASKIT.

## Kidney Health Care

**Table 10: Primary Diagnosis by Age, FY94**

Primary Diagnosis	0-20		21-34		35-44		45-54		55-64		65-74		75+		Total	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
Diabetes	5	7.5	71	21.7	155	35.6	330	53.7	508	60.7	443	53.3	123	29.9	1635	46.4
Hypertension	6	9.0	70	21.4	117	26.8	165	26.8	209	25.0	256	30.8	199	48.4	1022	29.0
Glomerulo-nephritis	25	37.3	78	23.9	89	20.4	62	10.1	54	6.5	68	8.2	46	11.2	422	12.0
Unknown Etiology	7	10.4	27	8.3	21	4.8	12	2.0	17	2.0	19	2.3	8	1.9	111	3.1
Congenital Anomalies	12	17.9	11	3.4	17	3.9	20	3.3	16	1.9	18	2.2	7	1.7	101	2.9
Urinary System Disease	3	4.5	17	5.2	10	2.3	4	0.7	12	1.4	15	1.8	15	3.6	76	2.2
Connective Tissue Disease	4	6.0	36	11.0	13	3.0	15	2.4	5	0.6	3	0.4	3	0.7	79	2.2
Malignant Neoplasm	0	0.0	1	0.3	1	0.2	3	0.5	11	1.3	7	0.8	10	2.4	33	0.9
HIV/AIDS	0	0.0	10	3.1	5	1.1	2	0.3	1	0.1	0	0.0	0	0.0	18	0.5
Metabolic Disease	1	1.5	1	0.3	0	0.0	1	0.2	1	0.1	0	0.0	0	0.0	4	0.1
Blood Diseases	1	1.5	0	0.0	3	0.7	0	0.0	2	0.2	0	0.0	0	0.0	6	0.2
Other	3	4.4	5	1.4	5	1.2	1	0.0	1	0.2	2	0.2	0	0.2	17	0.5
<b>Total</b>	<b>67</b>	<b>100</b>	<b>327</b>	<b>100</b>	<b>436</b>	<b>100</b>	<b>615</b>	<b>100</b>	<b>837</b>	<b>100</b>	<b>831</b>	<b>100</b>	<b>411</b>	<b>100</b>	<b>3524</b>	<b>100</b>

As of 10/05/2005, ASKIT.

**Table 11: Primary Diagnosis by Age, FY04**

Primary Diagnosis	0-20		21-34		35-44		45-54		55-64		65-74		75+		Total	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
Diabetes	3	7.5	59	19.2	207	42.0	549	57.5	743	66.9	520	59.8	221	40.3	2302	53.3
Hypertension	6	15.0	86	28.0	123	24.9	219	22.9	189	17.0	230	26.4	223	40.7	1076	24.9
Glomerulo-nephritis	8	20.0	69	22.5	66	13.4	69	7.2	64	5.8	40	4.6	33	6.0	349	8.1
Unknown Etiology	6	15.0	20	6.5	19	3.9	28	2.9	10	0.9	13	1.5	19	3.5	115	2.7
Congenital Anomalies	7	17.5	9	2.9	17	3.4	26	2.7	14	1.3	6	0.7	2	0.4	81	1.9
Urinary System Disease	7	17.5	28	9.1	29	5.9	30	3.1	56	5.0	41	4.7	30	5.5	221	5.1
Connective Tissue Disease	2	5.0	23	7.5	12	2.4	9	0.9	4	0.4	1	0.1	1	0.2	52	1.2
Malignant Neoplasm	0	0.0	2	0.7	3	0.6	6	0.6	14	1.3	12	1.4	10	1.8	47	1.1
HIV/AIDS	0	0.0	5	1.6	11	2.2	10	1.0	0	0.0	0	0.0	0	0.0	26	0.6
Metabolic Disease	0	0.0	3	1.0	2	0.4	3	0.3	5	0.5	3	0.3	1	0.2	17	0.4
Blood Diseases	0	0.0	0	0.0	0	0.0	2	0.2	2	0.2	1	0.1	0	0.0	5	0.1
Other	1	2.5	3	1.0	4	0.9	4	0.7	9	0.7	3	0.4	8	1.4	32	0.6
<b>Total</b>	<b>40</b>	<b>100</b>	<b>307</b>	<b>100</b>	<b>493</b>	<b>100</b>	<b>955</b>	<b>100</b>	<b>1110</b>	<b>100</b>	<b>870</b>	<b>100</b>	<b>548</b>	<b>100</b>	<b>4323</b>	<b>100</b>

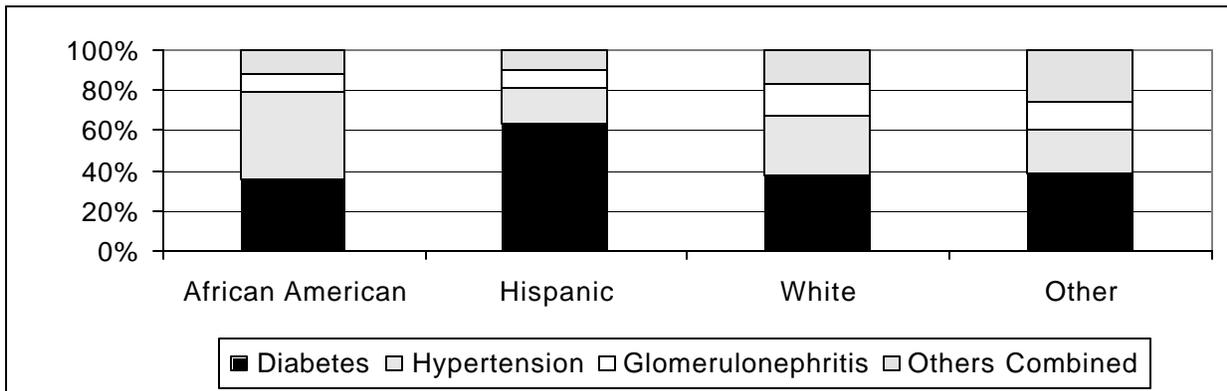
As of 10/05/2005, ASKIT.

## Primary Diagnosis by Ethnic Group

The distribution of ESRD among KHC approved applicants reveals increased growth in diabetes as a primary diagnosis among all ethnic groups between FY94 and FY04. Most notable is the percentage of FY04 applicants within the Hispanic group whose kidneys failed due to diabetes (68.7%). This percentage has increased from FY94, when 63.5% of Hispanics approved for KHC benefits had this primary diagnosis. In FY04, the percentage of approved applicants with this primary diagnosis in the KHC general population was 53.3%.

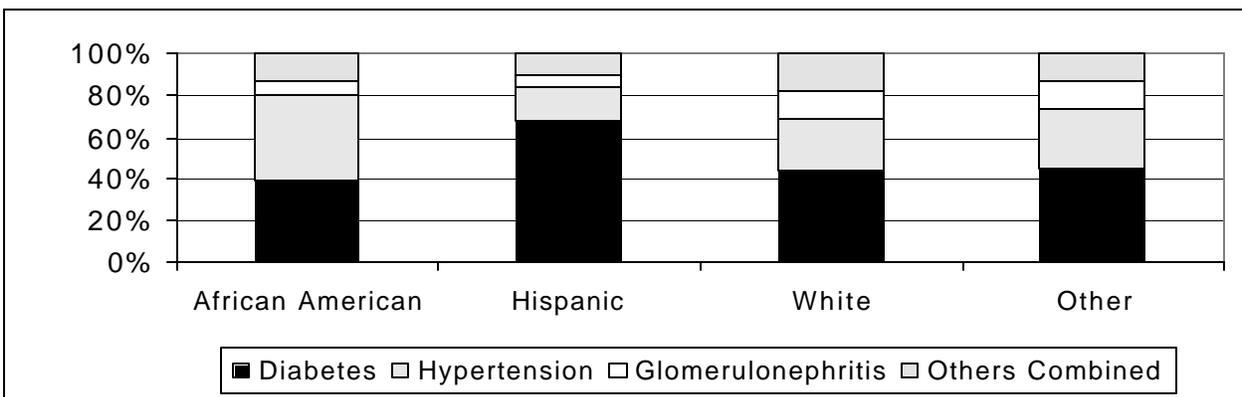
While Hispanics are disproportionately affected by diabetes as a primary diagnosis of ESRD, African American applicants on the KHC program are disproportionately affected by hypertension. Hypertension as a primary diagnosis accounted for 40% of all FY04 applicants within this ethnic group.

**Figure 12: Primary Diagnosis by Ethnic Group, FY94**



*As of 10/05/04, ASKIT.*

**Figure 13: Primary Diagnosis by Ethnic Group, FY04**



*As of 10/05/04, ASKIT.*

## Kidney Health Care

**Table 12: Primary Diagnosis by Ethnic Group, FY94**

Primary Diagnosis	African American		Hispanic		White		Other		Total	
	Count	%	Count	%	Count	%	Count	%	Count	%
Diabetes	327	35.4	798	63.5	484	38.0	26	38.2	1,635	46.4
Hypertension	407	44.0	228	18.1	372	29.2	15	22.1	1,022	29.0
Glomerulonephritis	89	9.6	119	9.5	204	16.0	10	14.7	422	12.0
Unknown Etiology	27	2.9	39	3.1	38	3.0	7	10.3	111	3.1
Congenital Anomalies	9	1.0	19	1.5	70	5.5	3	4.4	101	2.9
Urinary System Disease	9	1.0	17	1.4	45	3.5	5	7.4	76	2.2
Connective Tissue Disease	29	3.1	24	1.9	24	1.9	2	2.9	79	2.2
Malignant Neoplasm	7	0.8	6	0.5	20	1.6	0	0.0	33	0.9
HIV/AIDS	17	1.8	0	0.0	1	0.1	0	0.0	18	0.5
Metabolic Disease	0	0.0	1	0.1	3	0.2	0	0.0	4	0.1
Blood Diseases	3	0.3	2	0.2	1	0.1	0	0.0	6	0.2
Other	1	0.1	4	0.2	12	0.9	0	0.0	17	0.5
<b>Total</b>	<b>925</b>	<b>100</b>	<b>1,257</b>	<b>100</b>	<b>1,274</b>	<b>100</b>	<b>68</b>	<b>100</b>	<b>3,524</b>	<b>100</b>

As of 9/01/2004, ASKIT.

**Table 13: Primary Diagnosis by Ethnic Group, FY04**

Primary Diagnosis	African American		Hispanic		White		Other		Total	
	Count	%	Count	%	Count	%	Count	%	Count	%
Diabetes	456	39.8	1,221	68.7	575	44.6	50	45.5	2,302	53.3
Hypertension	459	40.1	266	15.0	320	24.8	31	28.2	1,076	24.9
Glomerulonephritis	80	7.0	97	5.5	158	12.2	14	12.7	349	8.1
Unknown Etiology	15	1.3	54	3.0	45	3.5	1	0.9	115	2.7
Congenital Anomalies	10	0.9	29	1.6	41	3.2	1	0.9	81	1.9
Urinary System Disease	47	4.1	68	3.8	98	7.6	8	7.3	221	5.1
Connective Tissue Disease	22	1.9	21	1.2	6	0.5	3	2.7	52	1.2
Malignant Neoplasm	15	1.3	10	0.6	22	1.7	0	0.0	47	1.1
HIV/AIDS	22	1.9	3	0.2	1	0.1	0	0.0	26	0.6
Metabolic Disease	3	0.3	3	0.2	10	0.8	1	0.9	17	0.4
Blood Diseases	5	0.4	0	0.0	0	0.0	0	0.0	5	0.1
Other	11	1.0	6	0.2	14	1.0	1	0.9	32	0.6
<b>Total</b>	<b>1,145</b>	<b>100</b>	<b>1,778</b>	<b>100</b>	<b>1,290</b>	<b>100</b>	<b>110</b>	<b>100</b>	<b>4,323</b>	<b>100</b>

As of 9/01/2004, ASKIT.

### Primary Diagnosis by Gender

Table 14 and Figure 14 report on primary diagnosis by gender. There are several differences to note regarding the distribution of ESRD by gender. For example, the percentage of female applicants with a primary diagnosis of diabetes is higher than that of males, but male applicants with a primary

diagnosis of hypertension continue to outnumber females.

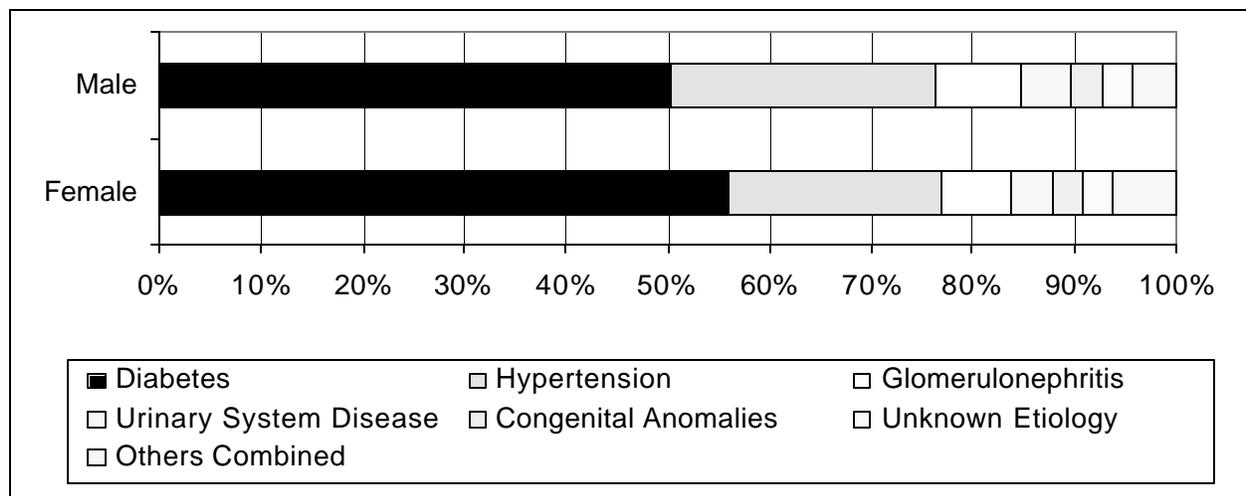
In FY04, male applicants experienced a 29% greater difference in urinary system disease versus females, and females experienced an 81% greater difference of connective tissue disease than males.

**Table 14: Primary Diagnosis by Gender, FY04**

Primary Diagnosis	Female	% Total	Male	% Total	Total	% Total
Diabetes	1,072	56.0	1,230	51.0	2,302	53.3
Hypertension	430	22.5	646	26.8	1,076	24.9
Glomerulonephritis	133	7.0	216	9.0	349	8.1
Unknown Etiology	49	2.6	66	2.7	115	2.7
Congenital Anomalies	38	2.0	43	1.8	81	1.9
Urinary System Disease	92	4.8	129	5.4	221	5.1
Connective Tissue Disease	44	2.3	8	0.3	52	1.2
Malignant Neoplasm	18	0.9	29	1.2	47	1.1
HIV/AIDS	6	0.3	20	0.8	26	0.6
Metabolic Disease	8	0.4	9	0.4	17	0.4
Blood Disease	3	0.2	2	0.1	5	0.1
Other	20	1.0	12	0.5	32	0.6
<b>Total</b>	<b>1,913</b>	<b>100</b>	<b>2,410</b>	<b>100</b>	<b>4,323</b>	<b>100</b>

As of 10/01/2004, ASKIT.

**Figure 14: Primary Diagnosis by Gender, FY04**



**Primary Diagnosis Trends**

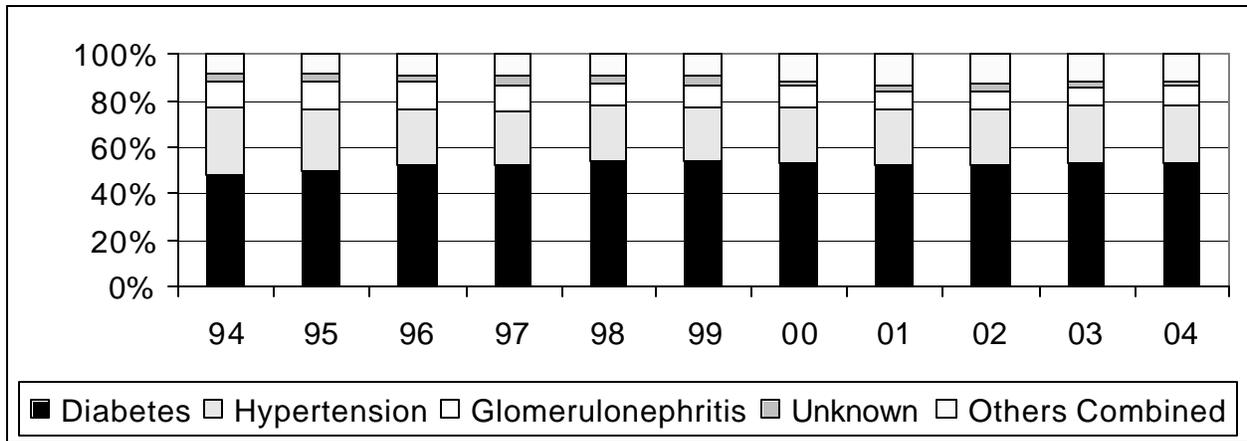
Figure 15 illustrates trends in KHC primary diagnoses, and shows that an increase in the growth of KHC applicants with a primary diagnosis of diabetes has occurred over the 10-year period. In FY94, there were 1,635 diabetic applicants, or 46.4% of the KHC incident population. In FY04, that number increased to 2,302 applicants, or 53.3% of the KHC incident population.

of cases in 1994, and increased to 43,922 patients, or 45% in 2002. Both state and national data reflect the continuing incidence of diabetes.

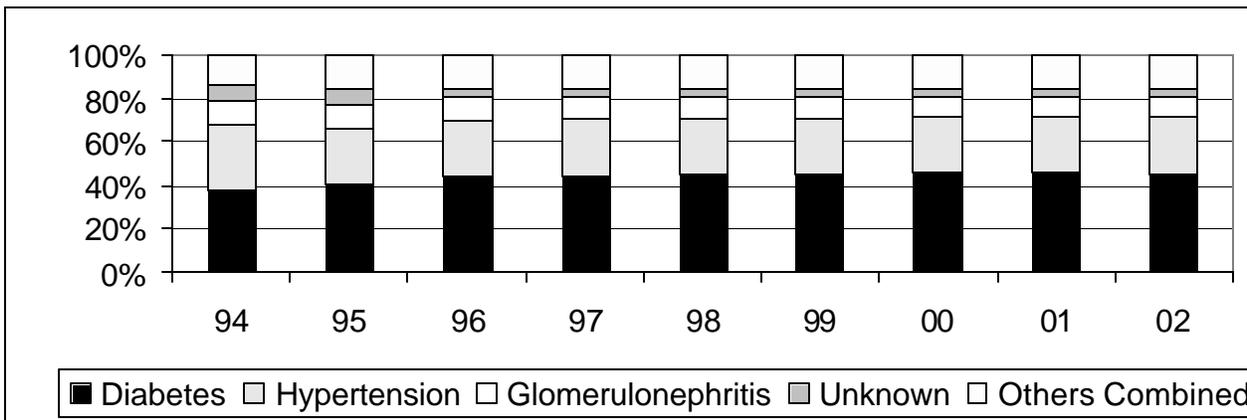
It should be noted that the percentage of KHC applicants with a primary diagnosis of diabetic nephropathy is consistently higher than the national average for all years reported, which may be due to the high incidence of diabetes among the KHC general population, and particularly within the Hispanic group.

Figure 16 illustrates the growth of the diabetic ESRD population on a national level. Diabetes as a primary diagnosis accounted for 25,433 patients, or 38%

**Figure 15: KHC Trends in Primary Diagnoses, FY94-FY04**



**Figure 16: National Trends in Primary Diagnoses, 1994-2002**  
**Source: United States Renal Data System 2004 Annual Data Report**



# Treatment Status

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## Treatment Status

Prior to the development of successful treatment for kidney failure, the deterioration of kidney function was almost always fatal. During the 1960s and early 1970s, the artificial kidney machine, peritoneal dialysis, and kidney transplantation became viable and practical treatment options for ESRD patients. All of these treatments are widely available today, allowing ESRD patients effective, long-term treatment choices.

Advances in the field of renal replacement therapy have continued, including the use of living and cadaveric organs for transplantation, effective immunosuppressive drug therapies, peritoneal dialysis methods, and more efficient and practical techniques for improving the life expectancy and quality of life for ESRD patients. This section provides an overview of the treatment modalities available to ESRD patients and reports on modality information for the KHC population.

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### Treatment Choices

It was not until the early 1940s that Dr. Willem Kolff invented the first dialysis machine. Although this led to lifesaving treatment, the first dialyzer operated slowly and unsanitarily. Since then, nephrologists have made great strides in the treatment of kidney disease. Today, there are two types of dialysis available for the treatment of ESRD, hemodialysis and peritoneal dialysis.

#### Hemodialysis

*Hemodialysis* cleans and filters the blood through the use of an artificial kidney machine, or dialyzer. It removes toxins, harmful wastes, and excess salts and fluids from the blood. It also controls blood pressure and helps the body keep the proper

balance of electrolytes. Hemodialysis is a process in which the patient's blood travels through tubes into a dialyzer through a vascular access site to clean the blood. After the dialyzer filters the wastes and excess fluids, the newly cleansed blood is returned to the patient's body through another set of tubes.

Although hemodialysis is performed mainly in dialysis centers, it can also be done at home with the assistance of a trained person. Hemodialysis (in-center and home) is usually performed three times a week and each treatment lasts between three to five hours.

#### Peritoneal Dialysis

*Peritoneal dialysis* (PD) is another procedure that replaces the work of the kidneys. Peritoneal dialysis uses the lining of the abdomen (peritoneum) to filter toxins from the bloodstream. Using a surgically implanted catheter, the abdominal cavity is filled with dialysate fluid. The peritoneum acts as a membrane, drawing out toxins from the blood and into the dialysate-filled abdominal cavity. The dialysate fluid is then removed from the abdominal cavity after a certain period of time, which varies by patient and the method of peritoneal dialysis used.

Two peritoneal dialysis methods are currently used. The most common type is *Continuous Ambulatory Peritoneal Dialysis* (CAPD). With CAPD, the blood is constantly being cleansed. The patient manually inserts the dialysate fluid into the abdomen through a catheter and replaces it with a fresh supply once the cleansing process has completed. The process is performed several times during the day, typically four to six hours per exchange. CAPD does not require the use of a machine.

*Continuous Cycling Peritoneal Dialysis* (CCPD) is much like CAPD except that it uses a programmed machine (cyclor) to fill the abdomen with dialysate, and then it drains the fluid after the exchange, or cycle, has occurred. Each cycle takes about 45 minutes and is done multiple times throughout the night while the patient is sleeping.

### **Kidney Transplantation**

Kidney transplantation is another treatment modality available for the treatment of ESRD. Transplantation is the surgical placement of a donor's healthy kidney into the body of the recipient.

Kidney donors are classified as either living-related or living-unrelated to the recipient, or deceased donors. A living donor is a person who has two functioning kidneys, and voluntarily donates one of them to a recipient. Deceased donors are individuals who have suffered the irreversible loss of all functions of the brain, but whose major organ functions are being artificially sustained by mechanical support until transplantation into the recipient is accomplished.

After transplantation the immune system will try to fight off, or reject, the new kidney. To counteract organ rejection, transplant recipients must take immunosuppressive, or anti-rejection drugs for life. These drugs suppress the body's immune system by decreasing the natural defenses to foreign bodies so that the body will not try to destroy the new kidney.

Great scientific advances over the past forty years in the area of immunosuppressive drug therapy have improved the success rate of kidney transplantation, and kidney transplantation continues to evolve as an effective treatment for ESRD patients. Additionally, the success of solid-organ transplantation has increased the need for an

expanded supply of organ donors. However, a number of factors continue to exist which limit access to transplantation, such as the shortage of donor organs, medical compatibility, comorbidity, variation in selection criteria, geographical factors, and socioeconomic barriers.

Historically, it has been important for the donor and recipient's tissues to very closely match. Recently, scientific analysis has shown that tissue matching could be somewhat reduced while maintaining long-term graft survival. Due to improvements in immunosuppressive drug therapy, improved graft outcomes have been achieved, despite a lack of stringent tissue matching. Transplantation policy has therefore evolved to allow kidney sharing between individuals with less emphasis on matching requirements.

During the past five years, great emphasis has been placed on increasing the number of living organ donors. Because a person only requires one healthy kidney to live, and because of the shortage of life saving organs for transplant, more patients are turning to living organ donation. In calendar years 2001-2003, the number of living organ donors in the United States surpassed the number of cadaveric donors (Organ Procurement and Transplantation Network, November 18, 2004 data). Calendar year 2004 data is not yet available.

The Anatomical Gift Educational Program of the DSHS was established in 1999 to educate Texans on the laws, benefits, and procedures governing organ donation. The AGEPE provides education and outreach grants to organizations in Texas, and has been tasked with encouraging nursing and medical schools to include mandatory organ donor education in their curricula, as well as encouraging attorneys to provide organ donor information to clients seeking end-of-life decision making information.

## Treatment Modality

There are various factors that influence the selection of treatment modality among ESRD patients, such as age, personal and physician preference, and co-morbid conditions.

In FY04, in-center hemodialysis was the predominant treatment modality among KHC recipients and comprised 72.6% of the KHC

prevalent population. Of the remaining patients in FY04, 6.3% were receiving home dialysis and 21.1% were transplant patients.

Figures 17, 18, and 19 on pages 28 and 29 show the distribution of treatment modalities among KHC recipients by age, gender, and ethnicity.

**Table 15: Treatment Status by Age, Gender, and Ethnic Group, FY04**

Age	In-Center			Home Dialysis			Transplant		Totals	
	FH	FP	SH	CA	CC	HH	LT	CT	Total	% of Total
0-20	13	0	0	3	12	0	16	14	58	0.3
21-34	942	2	0	93	68	3	207	488	1,803	7.4
35-44	1,834	2	3	156	103	4	287	876	3,265	13.5
45-54	3,629	1	3	220	122	3	255	1,103	5,336	22.0
55-64	4,637	2	5	237	121	6	198	934	6,140	25.3
65-74	3,991	4	0	160	118	1	105	542	4,921	20.3
75 & Over	2,527	3	0	46	61	1	8	70	2,716	11.2
Gender	FH	FP	SH	CA	CC	HH	LT	CT	Total	% of Total
Female	8,390	10	3	458	323	8	467	1,676	11,335	46.8
Male	9,183	4	8	457	282	10	609	2,351	12,904	53.2
Ethnic Group	FH	FP	SH	CA	CC	HH	LT	CT	Total	% of Total
African American	5,642	3	5	204	116	4	112	901	6,987	28.8
Hispanic	7,856	7	2	370	246	1	503	1,544	10,529	43.4
White	3,706	3	4	325	222	13	426	1,428	6,127	25.3
Other	369	1	0	16	21	0	35	154	596	2.5
All Groups	FH	FP	SH	CA	CC	HH	LT	CT	Total	
<b>Total</b>	17,573	14	11	915	605	18	1,076	4,027	24,239	
% of Total	72.5	0.1	0.0	3.8	2.5	0.1	4.4	16.6	Total Currently Eligible	
Modality Total	17,598			1,538			5,103			
% of Total	72.6%			6.3%			21.1%		24,239	

As of 10/06/04, ASKIT.

FH: Facility Hemodialysis  
FP: Facility Peritoneal Dialysis  
SH: Self Hemodialysis

CA: Continuous Ambulatory Peritoneal Dialysis  
CC: Continuous Cycling Peritoneal Dialysis  
HH: Home Hemodialysis

LT: Living Transplant  
CT: Cadaveric Transplant

**Treatment Status by Age and Gender**

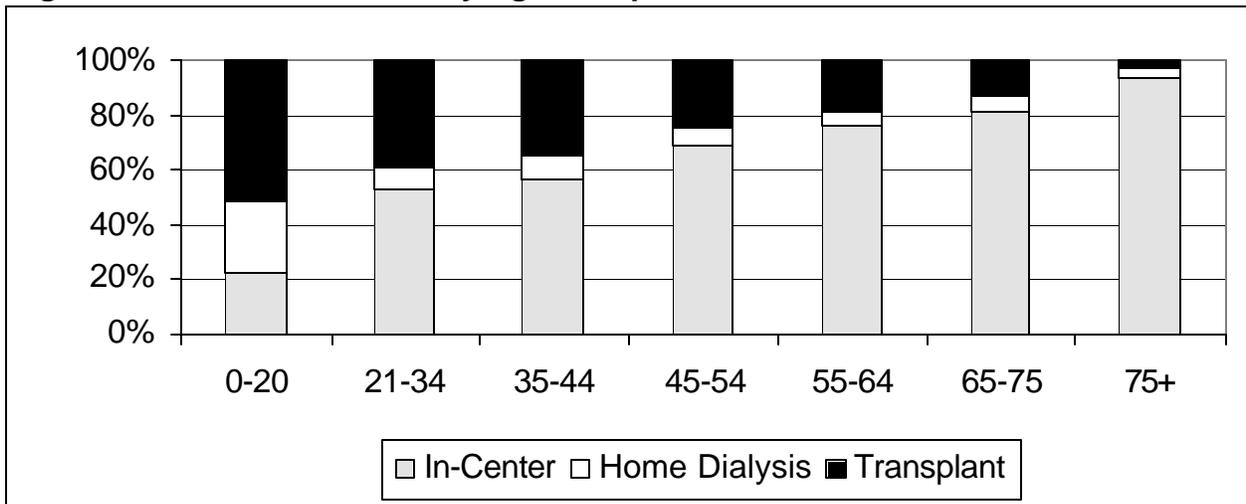
Figure 17 shows that in-center hemodialysis is the predominant treatment modality among all KHC age groups with the exception of those in the 0-20 group. More patients within this age group have kidney transplants, or are receiving home dialysis.

population - 82% of whom are hemodialysis patients and 18% of whom are transplant patients. The highest percentage of hemodialysis treatment occurs within the 75+ age group.

While the number of male and female recipients are fairly comparable with regard to in-center modality status, gender differences are evident in regard to transplant status, with male transplant recipients outnumbering their female counterparts by 38%.

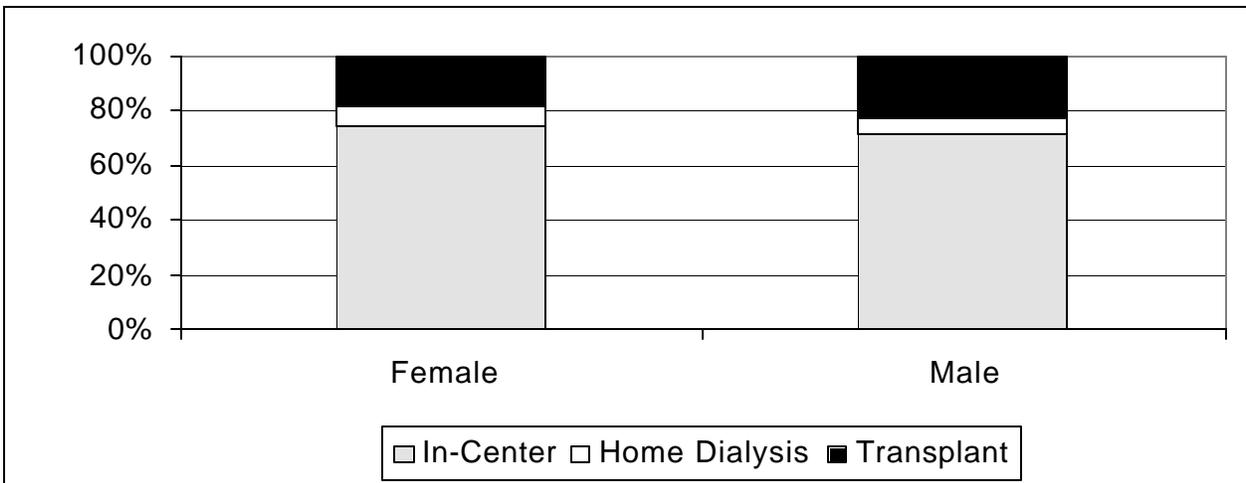
Recipients within the 55-64 age group comprise the largest proportion of the KHC prevalent

**Figure 17: Treatment Status by Age Group, FY04**



*As of 10/06/04, ASKIT.*

**Figure 18: Treatment Status by Gender, FY04**



*As of 10/06/04, ASKIT.*

## Treatment Status by Ethnic Group

When looking at treatment status by ethnic group, differences exist within treatment modalities between these groups. While in-center dialysis is the predominant treatment modality for all ethnic groups, the distribution of kidney transplants between ethnic groups is evident.

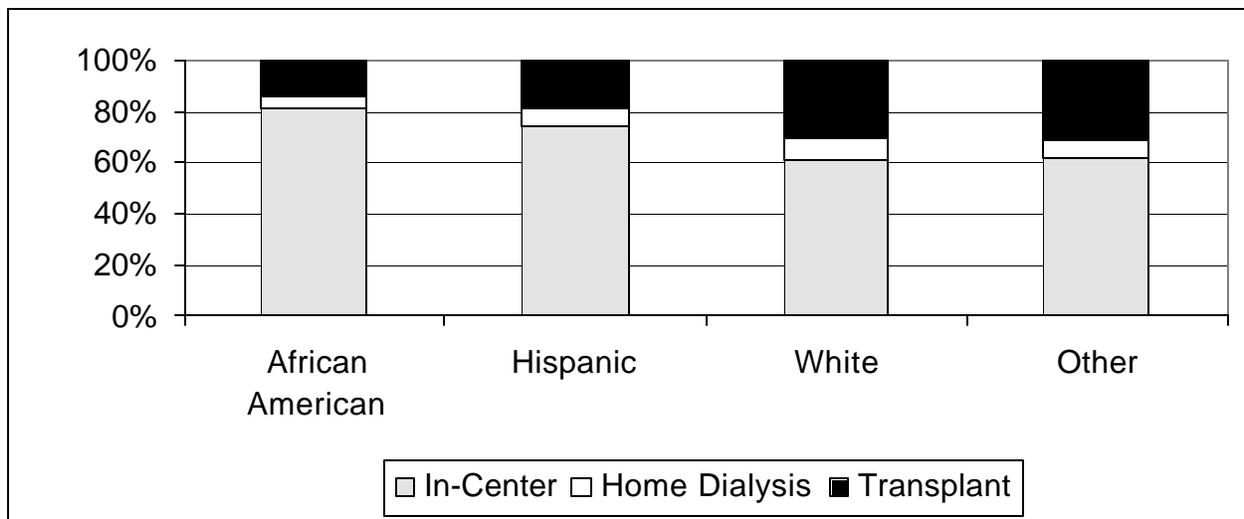
In FY04, Hispanic recipients comprised 39.5% of KHC transplant patients, Whites comprised 36.3%, while African Americans comprised only 19.8% of the KHC transplant population. Eighty-one percent of African American recipients are treated with in-center dialysis.

The need for African American organ donors continues to be a critical issue. African Americans represent 13% of the U.S. population but make up 35% of those waiting for a kidney transplant

on the national waiting list. Lower donation rates are one possible explanation for the longer wait times seen within this group. As a result of this disparity, numerous strategies and educational initiatives are directed at increasing the number of organ donors within this ethnic group, including the requirement of targeting minority groups through AGEF grant awards.

When looking at the KHC population, Hispanic recipients received transplants from 503 living donors and 1,544 cadaveric donors. White recipients received transplants from 426 living donors and 1,428 cadaveric donors. However, African American recipients only received transplants from 112 living donors and 901 cadaveric donors in FY04.

**Figure 19: Treatment Status by Ethnic Group, FY04**



As of 10/06/04, ASKIT.

**Table 16: ESRD Treatment Modality Trends - US<sup>1</sup> Compared with KHC**

Modality	1999		2000		2001		2002		2003		
	US	KHC	US	KHC	US	KHC	US	KHC	US	KHC	
I N - C E N T E R	Hemo	230,684	15,639	244,987	16,558	257,900	16,942	270,561	17,853	281,757	17,584
	% Change	6.8	15.7	6.2	5.9	5.3	2.3	4.9	5.4	4.0	-1.5
	PD	300	6	220	17	295	21	159	26	104	14
	% Change	-14.3	600	-26.7	183	34.1	19.0	-46.1	23.8	-52.9	-85.7
H O M E	Hemo	1,521	36	1,480	41	1,277	27	1,343	21	1,417	18
	% Change	-5.4	100	-2.7	13.9	-13.7	-51.9	5.2	-22.2	5.2	-16.7
	CAPD	13,320	1,022	12,548	1,132	11,642	917	11,249	945	10,662	915
	% Change	-10.6	41.7	-5.8	10.8	-7.2	-23.4	-3.4	3.1	-5.5	-3.3
	CCPD	13,620	573	14,098	673	14,868	551	15,711	596	16,604	605
	% Change	5.6	60.0	3.5	17.5	5.5	-22.1	5.7	8.2	5.4	1.5
T R A N S P L A N T	Living	4,644	874	5,427	962	5,804	887	6,141	1,006	6,208	1,076
	% Change	2.7	62.5	16.9	10.1	6.9	-8.5	5.8	13.4	1.1	6.5
	Cad.	8,839	3,588	8,884	3,872	8,824	3,475	9,453	3,868	9,521	4,027
	% Change	1.0	61.2	.51	7.9	-7	-11.4	7.1	11.3	0.7	3.9

Notes: In-Center Hemodialysis includes assisted in-center hemodialysis and peritoneal dialysis. Home Dialysis includes CAPD, CCPD, and hemodialysis. Living transplant includes related and non-related donors.

**ESRD Treatment Modality Trends**

This table reports the trends in the treatment of ESRD from 1999-2003 and compares the percentage rate of change from each year to the next for each modality between KHC recipients and patients throughout the United States.

The largest growth occurred within the national and KHC transplant populations, which experienced increases in both the number of living and deceased

donor transplants. Particular attention should be paid to the increase in living transplants, as more people are turning to living organ donors as a solution to the shortage of deceased donor kidneys available for transplantation.

In the 2003 year column, the most current data available for the U.S. is *Calendar Year 2003* - the KHC data reported is *Fiscal Year 2004*.

<sup>1</sup> Source US Data: FORUM of ESRD Network Annual Report 2003



# **Incidence, Prevalence and Mortality**

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## Incidence, Prevalence, Mortality

This chapter presents information on the incidence, prevalence, and mortality of the KHC ESRD population. *Incidence* is defined as the rate at which new cases of disease occur in a population during a specific period of time, or the rate of occurrence of a disease over a given period of time. For KHC data, incidence refers to the number of new applicants approved for benefits in the fiscal year being reported. This number does not include all of the new cases of ESRD in the state, but only those patients who apply for and are approved for KHC benefits. Incidence can be used as a population measure of the rate of occurrence of kidney disease.

*Prevalence* is defined as the number of individuals (per million) in a population who are affected with a particular disease during a given time period (period prevalence), and can be used as a population measure of disease burden and resource requirements. In the KHC Annual Report, prevalence rates are calculated using the number of recipients who were eligible at any time during the fiscal year being reported. This number does not include all of those affected with ESRD in the state, but only those KHC recipients who were eligible to receive benefits from KHC during the fiscal year being reported. Prevalence rates are affected by the number of new patients who come into the program and by the number of patients leaving the program.

Tables 17 and 18 in this chapter show the distribution of incidence and prevalence rates for FY94 and FY04 KHC applicants and recipients by age, gender, and ethnicity. The overall incidence rate for the KHC population (195 per million) continues to grow. Incidence rates increase as age increases, until age 75. The rates of new ESRD cases are higher for males than females, with rates at 218 and 172 per million, respectively.

**Figure 20: Incidence per Million by Ethnic Group, FY94 & FY04**

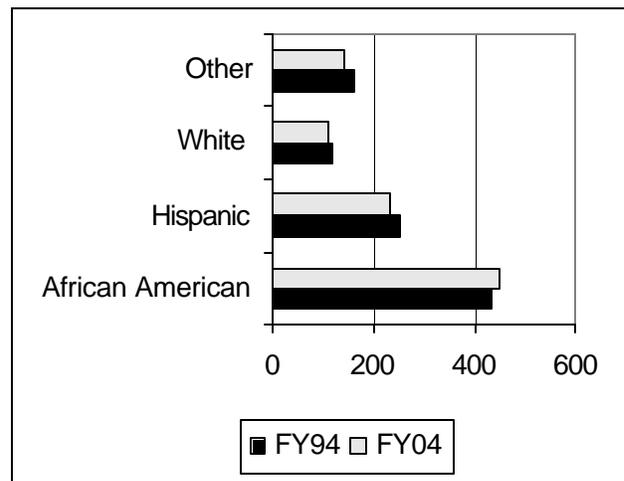


Figure 20 shows that the greatest disparity in KHC incidence rates exists between ethnic groups. The incidence rate for African Americans (565 per million) is the highest by race -- in fact, the rate for African Americans is more than twice the rate for the general population and almost four times higher than that of the White group.

Much like incidence, prevalence rates increase as age increases, until age 75. The rate of prevalent ESRD patients in FY04 is higher for males than females, with rates at 1,169 and 1,019 per million, respectively (Table 19, page 33).

For the KHC program, the greatest disparity in prevalence rates exists between ethnic groups. The prevalence rate for African Americans (2,741 per million) is more than five times larger than the prevalence rate of the White group (544 per million), and almost twice the rate of the Hispanic group (1,394). The overall prevalence rate for the KHC population continues to grow, at 1,094 cases per million, as compared to 711 per million in FY94.

## Kidney Health Care

**Table 17: Incidence by Age, Gender and Ethnicity, Per Million**

Age Group	1994			2004		
	Applicants	Incidence	1994 Population	Applicants	Incidence	2004 Population
0-20	67	11	6,197,957	40	6	7,094,450
21-34	327	79	4,131,080	307	66	4,637,672
35-44	436	152	2,877,614	493	148	3,329,756
45-54	615	311	1,978,003	955	322	2,962,828
55-64	837	631	1,326,398	1,110	572	1,940,510
65-74	831	775	1,071,658	870	728	1,194,624
75 & Over	411	517	795,475	548	549	998,286
<b>Gender</b>						
Female	1,713	184	9,303,428	1,913	172	11,122,060
Male	1,811	200	9,074,757	2,410	218	11,036,066
<b>Ethnic Group</b>						
African American	925	432	2,141,275	1,145	449	2,548,851
Hispanic	1,257	252	4,978,510	1,778	235	7,553,619
White	1,274	118	10,831,359	1,290	114	11,267,243
Other	68	159	427,041	110	140	788,413
<b>KHC Incidence</b>	<b>3,524</b>	<b>192</b>	<b>18,378,185</b>	<b>4,323</b>	<b>195</b>	<b>22,158,126</b>

As of 10/06/04, ASKIT.

**Table 18: Incidence by Public Health Region, Per Million**

REGION	1994			2004		
	Applicants	Incidence	1994 Population	Applicants	Incidence	2004 Population
1	141	186	757,048	174	216	804,954
2	87	163	535,051	94	169	557,715
3	703	153	4,608,625	955	162	5,896,629
4	237	252	939,037	215	206	1,041,550
5	145	207	699,662	143	189	757,560
6	629	148	4,259,662	947	183	5,183,638
7	339	177	1,913,485	401	162	2,478,614
8	508	262	1,938,807	571	254	2,252,457
9	96	181	529,480	110	204	539,272
10	234	347	675,087	260	346	751,824
11	405	266	1,522,241	453	239	1,893,913
<b>Totals</b>	<b>3,524</b>	<b>192</b>	<b>18,378,185</b>	<b>4,323</b>	<b>195</b>	<b>22,158,126</b>

As of 10/06/04, ASKIT.

Table 19: Prevalence by Age, Gender and Ethnicity, Per Million

Age Group	1994		2004			
	Eligible Recipients	Prevalence	1994 Population	Eligible Recipients	Prevalence	2004 Population
0-20	Data unavailable due to changes in age groupings.		6,197,957	58	8	7,094,450
21-34			4,131,080	1,803	389	4,637,672
35-44			2,877,614	3,265	981	3,329,756
45-54			1,978,003	5,336	1,801	2,962,828
55-64			1,326,398	6,140	3,164	1,940,510
65-74			1,071,658	4,921	4,119	1,194,624
75 & Over			795,475	2,716	2,721	998,286
Gender						
Female	6,290	676	9,303,428	11,335	1,019	11,122,060
Male	6,769	746	9,074,757	12,904	1,169	11,036,066
Ethnic Group						
African American	3,877	1,811	2,141,275	6,987	2,741	2,548,851
Hispanic	4,518	908	4,978,510	10,529	1,394	7,553,619
White	4,429	409	10,831,359	6,127	544	11,267,243
Other	235	550	427,041	596	756	788,413
KHC Prevalence	<b>*13,059</b>	<b>711</b>	<b>18,378,185</b>	<b>24,239</b>	<b>1,094</b>	<b>22,158,126</b>

As of 10/06/04, ASKIT.

Table 20: Prevalence by Public Health Region, Per Million

REGION	1994		2004			
	Eligible Recipients	Prevalence	1994 Population	Eligible Recipients	Prevalence	2004 Population
1	621	820	757,048	864	1,073	804,954
2	320	598	535,051	518	929	557,715
3	2,678	581	4,608,625	5,152	874	5,896,629
4	846	901	939,037	1,189	1,142	1,041,550
5	600	858	699,662	822	1,085	757,560
6	2,439	573	4,259,662	5,078	980	5,183,638
7	1,215	635	1,913,485	2,289	923	2,478,614
8	1,863	961	1,938,807	3,380	1,501	2,252,457
9	350	661	529,480	537	996	539,272
10	690	1,022	675,087	1,269	1,688	751,824
11	1,444	949	1,522,241	3,141	1,658	1,893,913
Totals	<b>*13,066</b>	<b>711</b>	<b>18,378,185</b>	<b>24,239</b>	<b>1,094</b>	<b>22,158,126</b>

As of 10/06/04, ASKIT.

\* The disparity between these two numbers exists because of different dates of data sources. The number 13,059 is from the most current data source.

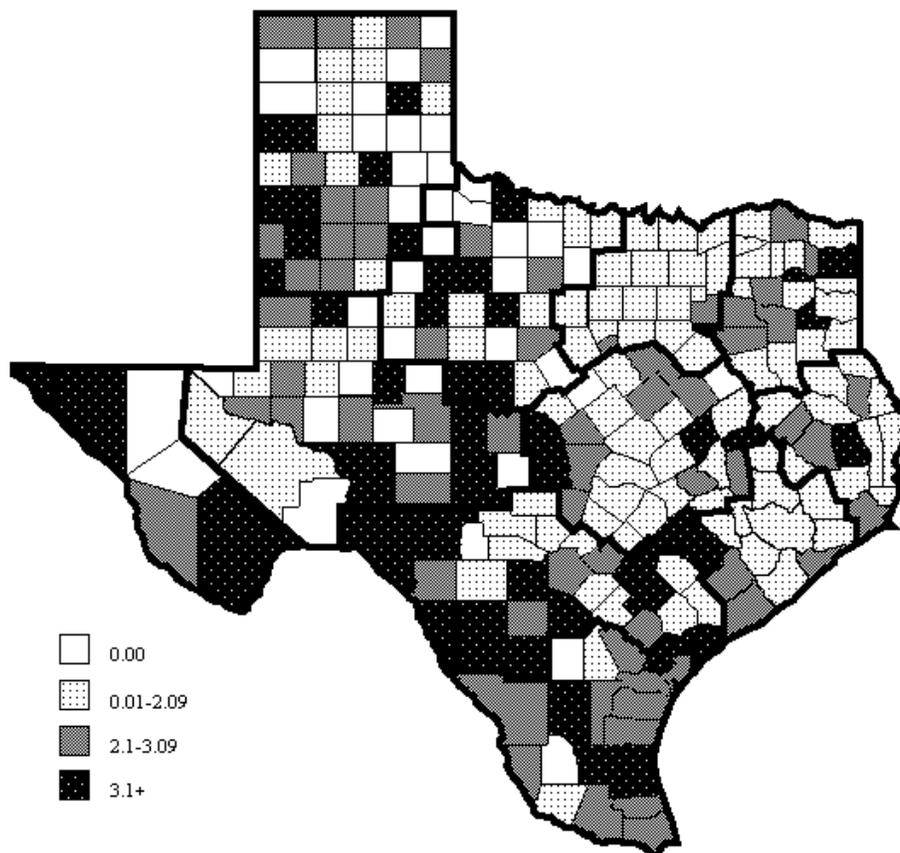
## Incidence by County

As previously mentioned, incidence is the number of individuals who applied for KHC benefits in a given fiscal year per 1,000,000 people in the general population. For the purpose of this report, incidence by county is reported as the number of new KHC applicants per 10,000 in the population. For example, the incidence rate for the state as a whole in FY04 was 1.95 per 10,000 residents. Using this figure, incidence by counties can be compared. For example, Dimmit County has a population of 10,525, so the number of applicants for that county, if typical, would be between two and three. However, in this example, the incidence rate is actually 4.75, as there were five KHC applicants from this county in FY04.

When the incidence rate is examined on a county by county basis, there is a wide range of variation.

In FY04, 38 counties had no applicants approved for KHC benefits, or zero incidence. Alternatively, 129 counties had an incidence rate at or above the state rate of 1.95. The highest incidence rate for any county was in Kenedy, at 22.83 per 10,000. This number however, is misleading, because Kenedy county has a population of 438, therefore, one applicant in FY04 inflates the rate for that county.

When comparing incidence rates with counties of similar population numbers, one can see there is great disparity. For example, the incidence rate of Bexar County is almost twice as high as that of Tarrant County. Similarly, the incidence rate of El Paso County is more than two times greater than that of Travis County. This may be due to the higher number of Hispanics in Bexar and El Paso counties and the high incidence of diabetes within this population.



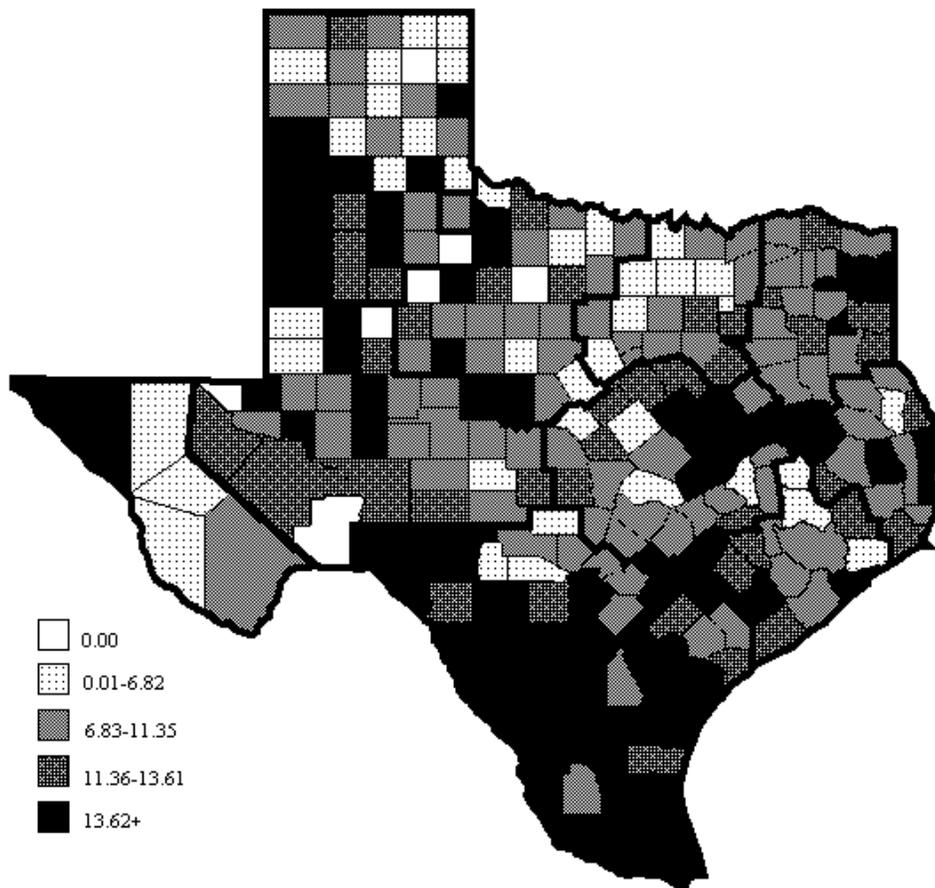
## Prevalence by County

Prevalence is defined as the number of individuals in a population (per million) who are affected with a particular disease over a given period of time (period prevalence). Despite the close interrelationship between incidence and prevalence, prevalence is perhaps a more useful measure of disease association for health care providers because prevalence measures can be used to assess the public health impact of a specific disease within a community. While incidence rates show the number of new applicants over a specific period of time, prevalence rates indicate the long-term accumulation of KHC recipients. For the purpose of this report, prevalence by county is reported as the number of KHC active recipients per 10,000 in the population. In many ways, the prevalence map presents a much clearer picture, because it shows where KHC active

recipients currently reside and where the need for benefits is the greatest.

The prevalence rate for the state as a whole in FY04 was 10.94 per 10,000 residents. However, when prevalence rates are examined on a county by county basis, we find that six counties had no active KHC recipients, or zero prevalence. Alternatively, 248 counties had active program recipients during FY04.

Much like incidence, when comparing prevalence rates with counties of similar population numbers, one can see that disparities exist. For example, the prevalence rate of Nueces County is three times as high as that of Montgomery County. Again, this is probably due to the higher number of Hispanics in Nueces County and the high prevalence of diabetes within this population.



## Kidney Health Care

**Table 21: Region 1 Incidence, Prevalence, and Expenditures by County**

<b>COUNTY</b>	<b>2004 County Population</b>	<b>FY04 Applicants</b>	<b>Incidence per 10,000</b>	<b>Eligible FY04 Recipients</b>	<b>Prevalence per 10,000</b>	<b>KHC FY04 Expenditures*</b>
Armstrong	2,153	0	0.00	2	9.29	\$ 2,120
Bailey	6,752	3	4.44	14	20.73	29,062
Briscoe	1,807	1	5.53	1	5.53	450
Carson	6,510	0	0.00	4	6.14	5,050
Castro	8,591	2	2.33	13	15.13	11,898
Childress	7,731	0	0.00	5	6.47	18,439
Cochran	3,847	1	2.60	7	18.20	10,226
Collingsworth	3,162	0	0.00	3	9.49	4,026
Crosby	7,305	2	2.74	14	19.16	7,400
Dallam	6,466	2	3.09	5	7.73	2,406
Deaf Smith	19,309	10	5.18	50	25.89	42,458
Dickens	2,730	3	10.99	2	7.33	456
Donley	3,798	0	0.00	2	5.27	7,599
Floyd	7,888	2	2.54	18	22.82	26,164
Garza	4,952	1	2.02	6	12.12	1,736
Gray	22,436	7	3.12	19	8.47	9,399
Hale	37,700	10	2.65	47	12.47	31,568
Hall	3,748	0	0.00	7	18.68	9,293
Hansford	5,466	1	1.83	5	9.15	19,317
Hartley	5,607	0	0.00	1	1.78	3,155
Hemphill	3,391	1	2.95	2	5.90	3,829
Hockley	23,427	8	3.41	38	16.22	85,346
Hutchinson	23,979	3	1.25	15	6.26	16,867
King	363	0	0.00	0	0.00	78
Lamb	14,956	5	3.34	28	18.72	34,653
Lipscomb	3,044	0	0.00	2	6.57	1,561
Lubbock	249,818	68	2.72	286	11.45	190,359
Lynn	6,701	2	2.98	9	13.43	5,496
Moore	21,232	4	1.88	15	7.06	27,366
Motley	1,413	0	0.00	1	7.08	881
Ochiltree	9,272	2	2.16	3	3.24	1,199
Oldham	2,254	0	0.00	2	8.87	2,220
Parmer	10,204	1	0.98	14	13.72	37,339
Potter	119,167	17	1.43	115	9.65	87,992
Randall	109,154	9	0.82	51	4.67	37,178
Roberts	894	0	0.00	0	0.00	0
Sherman	3,297	1	3.03	4	12.13	4,373
Swisher	8,502	1	1.18	12	14.11	27,578
Terry	13,163	3	2.28	19	14.43	21,646
Wheeler	5,148	1	1.94	8	15.54	4,986
Yoakum	7,617	3	3.94	15	19.69	28,630
<b>Region 1 Totals</b>	<b>804,954</b>	<b>174</b>	<b>2.16</b>	<b>864</b>	<b>10.73</b>	<b>\$ 861,800</b>

\* As of 11/05/04, ASKIT.

Table 22: Region 2 Incidence, Prevalence, and Expenditures by County

COUNTY	2004 County Population	FY04 Applicants	Incidence per 10,000	Eligible FY04 Recipients	Prevalence per 10,000	KHC FY04 Expenditures*
Archer	9,182	0	0.00	2	2.18	\$ 128
Baylor	3,976	0	0.00	4	10.06	5,335
Brown	38,271	8	2.09	35	9.15	17,451
Callahan	13,082	0	0.00	8	6.12	28,153
Clay	11,133	1	0.90	6	5.39	4,290
Coleman	9,143	5	5.47	13	14.22	6,284
Comanche	14,066	0	0.00	5	3.55	981
Cottle	1,864	0	0.00	2	10.73	4,687
Eastland	18,256	4	2.19	17	9.31	24,253
Fisher	4,296	2	4.66	4	9.31	10,381
Foard	1,605	0	0.00	3	18.69	2,971
Hardeman	4,669	0	0.00	3	6.43	1,988
Haskell	5,934	2	3.37	7	11.80	18,610
Jack	8,858	0	0.00	7	7.90	3,544
Jones	20,930	2	0.96	23	10.99	17,977
Kent	841	0	0.00	0	0.00	0
Knox	4,197	1	2.38	7	16.68	7,965
Mitchell	9,693	0	0.00	11	11.35	8,878
Montague	19,357	4	2.07	15	7.75	8,829
Nolan	16,089	4	2.49	24	14.92	32,167
Runnels	11,581	6	5.18	16	13.82	15,188
Scurry	16,529	3	1.81	21	12.70	44,558
Shackelford	3,330	3	9.01	3	9.01	2,464
Stephens	9,706	2	2.06	11	11.33	16,443
Stonewall	1,680	1	5.95	4	23.81	6,003
Taylor	130,536	18	1.38	112	8.58	86,822
Throckmorton	1,848	0	0.00	0	0.00	0
Wichita	134,262	18	1.34	116	8.64	57,438
Wilbarger	14,853	5	3.37	17	11.45	14,578
Young	17,948	5	2.79	22	12.26	28,913
<b>Region 2 Totals</b>	<b>557,715</b>	<b>94</b>	<b>1.69</b>	<b>518</b>	<b>9.29</b>	<b>\$ 477,277</b>

\* As of 11/05/04, ASKIT.

## Kidney Health Care

**Table 23: Region 3 Incidence, Prevalence, and Expenditures by County**

<b>COUNTY</b>	<b>2004 County Population</b>	<b>FY04 Applicants</b>	<b>Incidence per 10,000</b>	<b>Eligible FY04 Recipients</b>	<b>Prevalence per 10,000</b>	<b>KHC FY04 Expenditures*</b>
Collin	560,454	40	0.71	197	3.52	\$ 216,988
Cooke	37,215	7	1.88	19	5.11	31,008
Dallas	2,355,204	481	2.04	2,739	11.63	2,154,846
Denton	496,427	44	0.89	204	4.11	164,738
Ellis	120,342	22	1.83	116	9.64	93,869
Erath	34,369	4	1.16	21	6.11	32,627
Fannin	31,949	6	1.88	27	8.45	22,827
Grayson	113,372	18	1.59	99	8.73	103,204
Hood	43,939	7	1.59	31	7.06	26,139
Hunt	81,722	10	1.22	76	9.30	52,407
Johnson	136,201	28	2.06	98	7.20	114,048
Kaufman	77,905	20	2.57	92	11.81	97,448
Navarro	46,677	3	0.64	54	11.57	36,625
Palo Pinto	27,718	5	1.80	19	6.85	24,257
Parker	94,880	7	0.74	53	5.59	50,168
Rockwall	47,973	10	2.08	25	5.21	25,296
Somervell	7,075	2	2.83	6	8.48	10,437
Tarrant	1,530,647	230	1.50	1,245	8.13	891,478
Wise	52,560	11	2.09	31	5.90	27,424
<b>Region 3 Totals</b>	<b>5,896,629</b>	<b>955</b>	<b>1.62</b>	<b>5,152</b>	<b>8.74</b>	<b>\$ 4,175,833</b>

\* As of 11/05/04, ASKIT.

Table 24: Region 4 Incidence, Prevalence, and Expenditures by County

COUNTY	2004 County Population	FY04 Applicants	Incidence per 10,000	Eligible FY04 Recipients	Prevalence per 10,000	KHC FY04 Expenditures*
Anderson	56,185	10	1.78	57	10.15	\$ 60,245
Bowie	90,199	13	1.44	74	8.20	39,687
Camp	11,953	4	3.35	24	20.08	41,143
Cass	30,273	11	3.63	44	14.53	55,189
Cherokee	47,941	5	1.04	44	9.18	43,962
Delta	5,285	1	1.89	6	11.35	1,571
Franklin	9,481	1	1.05	10	10.55	15,418
Gregg	114,303	43	3.76	171	14.96	113,485
Harrison	64,218	11	1.71	79	12.30	89,038
Henderson	77,511	19	2.45	87	11.22	82,678
Hopkins	32,494	4	1.23	25	7.69	26,505
Lamar	48,874	3	0.61	51	10.43	26,599
Marion	11,086	2	1.80	17	15.33	15,804
Morris	13,036	4	3.07	19	14.58	17,122
Panola	22,991	3	1.30	27	11.74	15,150
Rains	9,632	1	1.04	13	13.50	16,926
Red River	14,259	3	2.10	19	13.32	17,816
Rusk	47,843	4	0.84	46	9.61	49,473
Smith	180,003	41	2.28	221	12.28	202,184
Titus	29,270	4	1.37	33	11.27	40,170
Upshur	36,456	5	1.37	35	9.60	25,977
Van Zandt	50,193	15	2.99	49	9.76	61,594
Wood	38,064	8	2.10	38	9.98	42,786
<b>Region 4 Totals</b>	<b>1,041,550</b>	<b>215</b>	<b>2.06</b>	<b>1,189</b>	<b>11.42</b>	<b>\$ 1,100,522</b>

\* As of 11/05/04, ASKIT.

## Kidney Health Care

**Table 25: Region 5 Incidence, Prevalence, and Expenditures by County**

COUNTY	2004 County Population	FY04 Applicants	Incidence per 10,000	Eligible FY04 Recipients	Prevalence per 10,000	KHC FY04 Expenditures*
Angelina	82,562	7	0.85	82	9.93	\$ 104,894
Hardin	49,857	8	1.60	48	9.63	57,482
Houston	23,143	3	1.30	32	13.83	25,175
Jasper	36,712	6	1.63	37	10.08	38,213
Jefferson	255,215	62	2.43	305	11.95	271,872
Nacogdoches	60,683	9	1.48	58	9.56	83,542
Newton	15,435	3	1.94	27	17.49	24,009
Orange	86,858	9	1.04	67	7.71	58,583
Polk	42,884	12	2.80	37	8.63	36,486
Sabine	10,453	1	0.96	13	12.44	16,627
San Augustine	8,988	2	2.23	5	5.56	10,772
San Jacinto	23,536	4	1.70	28	11.90	21,247
Shelby	25,728	5	1.94	26	10.11	29,072
Trinity	13,923	3	2.15	26	18.67	32,804
Tyler	21,583	9	4.17	31	14.36	37,656
<b>Region 5 Totals</b>	<b>757,560</b>	<b>143</b>	<b>1.89</b>	<b>822</b>	<b>10.85</b>	<b>\$ 848,434</b>

\* As of 11/05/04, ASKIT.

**Table 26: Region 6 Incidence, Prevalence, and Expenditures by County**

COUNTY	2004 County Population	FY04 Applicants	Incidence per 10,000	Eligible FY04 Recipients	Prevalence per 10,000	KHC FY04 Expenditures*
Austin	24,355	5	2.05	31	12.73	\$ 62,512
Brazoria	259,250	46	1.77	221	8.52	223,869
Chambers	28,090	2	0.71	8	2.85	14,384
Colorado	20,588	7	3.40	28	13.60	40,446
Fort Bend	392,202	53	1.35	276	7.04	282,172
Galveston	258,004	64	2.48	355	13.76	295,377
Harris	3,618,746	679	1.88	3,701	10.23	3,005,039
Liberty	74,696	15	2.01	87	11.65	79,191
Matagorda	38,889	10	2.57	50	12.86	40,512
Montgomery	326,694	39	1.19	183	5.60	175,128
Walker	64,226	10	1.56	43	6.70	33,278
Waller	35,850	7	1.95	33	9.21	47,004
Wharton	42,048	10	2.38	62	14.75	55,803
<b>Region 6 Totals</b>	<b>5,183,638</b>	<b>947</b>	<b>1.83</b>	<b>5,078</b>	<b>9.80</b>	<b>\$ 4,354,716</b>

\* As of 11/05/04, ASKIT.

Table 27: Region 7 Incidence, Prevalence, and Expenditures by County

COUNTY	2004 County Population	FY04 Applicants	Incidence per 10,000	Eligible FY04 Recipients	Prevalence per 10,000	KHC FY04 Expenditures*
Bastrop	64,329	13	2.02	67	10.42	\$ 107,590
Bell	255,365	33	1.29	224	8.77	124,050
Blanco	8,953	2	2.23	6	6.70	6,997
Bosque	17,556	3	1.71	21	11.96	35,433
Brazos	159,004	26	1.64	95	5.97	56,593
Burleson	17,181	4	2.33	17	9.89	20,724
Burnet	37,061	11	2.97	36	9.71	37,671
Caldwell	35,063	5	1.43	60	17.11	98,380
Coryell	80,755	12	1.49	47	5.82	37,263
Falls	18,895	2	1.06	37	19.58	38,879
Fayette	22,110	8	3.62	34	15.38	33,551
Freestone	18,118	0	0.00	18	9.93	20,783
Grimes	24,693	6	2.43	27	10.93	16,984
Hamilton	8,207	0	0.00	11	13.40	14,889
Hays	111,712	20	1.79	126	11.28	110,850
Hill	33,596	9	2.68	42	12.50	56,761
Lampasas	18,620	5	2.69	24	12.89	32,786
Lee	16,413	2	1.22	15	9.14	18,836
Leon	15,797	3	1.90	23	14.56	27,856
Limestone	22,508	5	2.22	32	14.22	36,489
Llano	16,610	6	3.61	21	12.64	24,179
Madison	219,295	5	3.75	11	8.26	9,943
McLennan	13,318	47	2.14	302	13.77	214,893
Milam	24,674	4	1.62	41	16.62	45,817
Mills	5,100	1	1.96	3	5.88	3,602
Robertson	16,387	6	3.66	36	21.97	30,194
San Saba	6,214	2	3.22	7	11.26	7,666
Travis	874,737	115	1.31	680	7.77	565,064
Washington	31,109	5	1.61	39	12.54	17,244
Williamson	285,234	41	1.44	187	6.56	152,272
<b>Region 7 Totals</b>	<b>2,478,614</b>	<b>401</b>	<b>1.62</b>	<b>2,289</b>	<b>9.23</b>	<b>\$ 2,004,240</b>

\* As of 11/05/04, ASKIT.

## Kidney Health Care

**Table 28: Region 8 Incidence, Prevalence, and Expenditures by County**

<b>COUNTY</b>	<b>2004 County Population</b>	<b>FY04 Applicants</b>	<b>Incidence per 10,000</b>	<b>Eligible FY04 Recipients</b>	<b>Prevalence per 10,000</b>	<b>KHC FY04 Expenditures*</b>
Atascosa	41,296	16	3.87	67	16.22	\$ 58,699
Bandera	19,064	3	1.57	12	6.29	13,271
Bexar	1,457,847	356	2.44	2,290	15.71	1,358,503
Calhoun	21,370	10	4.68	25	11.70	15,959
Comal	85,504	17	1.99	97	11.34	66,319
DeWitt	20,142	8	3.97	24	11.92	43,333
Dimmit	10,525	5	4.75	24	22.80	9,973
Edwards	2,227	1	4.49	6	26.94	13,210
Frio	17,010	5	2.94	39	22.93	32,886
Gillespie	21,016	1	0.48	10	4.76	9,040
Goliad	7,055	2	2.83	10	14.17	16,076
Gonzales	19,051	8	4.20	41	21.52	37,317
Guadalupe	95,974	28	2.92	103	10.73	65,932
Jackson	14,754	3	2.03	12	8.13	15,337
Karnes	16,016	1	0.62	26	16.23	25,051
Kendall	25,829	4	1.55	19	7.36	18,033
Kerr	44,081	7	1.59	37	8.39	34,132
Kinney	3,374	1	2.96	4	11.86	6,524
La Salle	6,142	3	4.88	13	21.17	13,546
Lavaca	18,971	4	2.11	31	16.34	33,656
Maverick	50,649	24	4.74	132	26.06	72,259
Medina	42,123	14	3.32	56	13.29	39,091
Real	3,037	0	0.00	2	6.59	776
Uvalde	26,914	5	1.86	45	16.72	24,891
Val Verde	47,486	17	3.58	92	19.37	62,866
Victoria	87,527	15	1.71	88	10.05	98,788
Wilson	35,461	5	1.41	36	10.15	40,739
Zavala	12,012	8	6.66	39	32.47	21,617
<b>Region 8 Totals</b>	<b>2,252,457</b>	<b>571</b>	<b>2.54</b>	<b>3,380</b>	<b>15.01</b>	<b>\$ 2,247,826</b>

\* As of 11/05/04, ASKIT.

Table 29: Region 9 Incidence, Prevalence, and Expenditures by County

COUNTY	2004 County Population	FY04 Applicants	Incidence per 10,000	Eligible FY04 Recipients	Prevalence per 10,000	KHC FY04 Expenditures*
Andrews	13,374	2	1.50	8	5.98	\$ 12,999
Borden	746	0	0.00	0	0.00	0
Coke	3,798	0	0.00	3	7.90	5,174
Concho	4,056	2	4.93	4	9.86	5,019
Crane	4,161	1	2.40	6	14.42	5,213
Crockett	4,241	2	4.72	5	11.79	9,723
Dawson	15,165	5	3.30	27	17.80	41,131
Ector	125,558	28	2.23	135	10.75	88,042
Gaines	15,081	4	2.65	10	6.63	9,688
Glasscock	1,461	0	0.00	2	13.69	1,480
Howard	33,923	3	0.88	41	12.09	27,200
Irion	1,817	0	0.00	2	11.01	1,893
Kimble	4,461	2	4.48	5	11.21	11,048
Loving	67	0	0.00	0	0.00	0
Martin	8,177	1	2.04	9	18.38	13,228
Mason	4,897	0	0.00	5	13.56	9,134
McCulloch	3,688	2	2.45	8	9.78	6,320
Menard	2,350	1	4.26	1	4.26	172
Midland	119,143	13	1.09	101	8.48	96,259
Pecos	17,167	3	1.75	21	12.23	35,500
Reagan	3,490	1	2.87	5	14.33	3,770
Reeves	13,486	2	1.48	16	11.86	40,530
Schleicher	3,004	0	0.00	3	9.99	7,207
Sterling	1,435	1	6.97	1	6.97	1,141
Sutton	4,253	1	2.35	5	11.76	8,469
Terrell	1,109	0	0.00	0	0.00	0
Tom Green	107,255	32	2.98	84	7.83	90,587
Upton	3,518	0	0.00	3	8.53	3,521
Ward	11,098	3	2.70	9	8.11	16,635
Winkler	7,293	1	1.37	18	24.68	42,539
<b>Region 9 Totals</b>	<b>539,272</b>	<b>110</b>	<b>2.04</b>	<b>537</b>	<b>9.96</b>	<b>\$ 593,621</b>

\* As of 11/05/04, ASKIT.

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**Table 30: Region 10 Incidence, Prevalence, and Expenditures by County**

<b>COUNTY</b>	<b>2004 County Population</b>	<b>FY04 Applicants</b>	<b>Incidence per 10,000</b>	<b>Eligible FY04 Recipients</b>	<b>Prevalence per 10,000</b>	<b>KHC FY04 Expenditures*</b>
Brewster	9,121	4	4.39	7	7.67	\$ 2,079
Culberson	3,133	0	0.00	2	6.38	3,517
El Paso	726,081	251	3.46	1,250	17.22	1,041,411
Hudspeth	3,534	3	8.49	6	16.98	9,908
Jeff Davis	2,256	0	0.00	1	4.43	2,117
Presidio	7,699	2	2.60	3	3.90	3,034
<b>Region 10 Totals</b>	<b>751,824</b>	<b>260</b>	<b>3.46</b>	<b>1,269</b>	<b>16.88</b>	<b>\$ 1,062,066</b>

\* As of 11/05/04, ASKIT.

**Table 31: Region 11 Incidence, Prevalence, and Expenditures by County**

<b>COUNTY</b>	<b>2004 County Population</b>	<b>FY04 Applicants</b>	<b>Incidence per 10,000</b>	<b>Eligible FY04 Recipients</b>	<b>Prevalence per 10,000</b>	<b>KHC FY04 Expenditures*</b>
Aransas	23,230	5	2.15	35	15.07	\$ 29,514
Bee	33,136	8	2.41	54	16.30	42,168
Brooks	8,201	3	3.66	18	21.95	11,764
Cameron	366,569	80	2.18	606	16.53	411,734
Duval	13,411	8	5.97	35	26.10	20,897
Hidalgo	636,492	141	2.22	1,048	16.47	701,703
Jim Hogg	5,387	0	0.00	5	9.28	9,135
Jim Wells	40,552	12	2.96	85	20.96	67,372
Kenedy	438	1	22.83	1	22.83	574
Kleberg	33,621	8	2.38	45	13.38	23,898
Live Oak	12,509	2	1.60	11	8.79	17,696
McMullen	870	0	0.00	2	22.99	2,331
Nueces	328,969	96	2.92	545	16.57	319,089
Refugio	7,969	3	3.76	16	20.08	15,962
San Patricio	72,434	20	2.76	111	15.32	82,933
Starr	58,498	5	0.85	101	17.27	47,967
Webb	217,741	53	2.43	362	16.63	219,039
Willacy	21,023	5	2.38	41	19.50	21,297
Zapata	12,863	3	2.33	20	15.55	29,223
<b>Region 11 Totals</b>	<b>1,893,913</b>	<b>453</b>	<b>2.39</b>	<b>3,141</b>	<b>16.58</b>	<b>\$ 2,074,295</b>

\* As of 11/05/04, ASKIT.

Table 32: Regional Incidence, Prevalence, and Expenditures

Region	2004 County Population	FY04 Applicants	Incidence per Million	Eligible FY04 Recipients	Prevalence per Million	KHC FY04 Expenditures*
1	804,954	174	216	864	1,073	\$ 861,800
2	557,715	94	169	518	929	477,277
3	5,896,629	955	162	5,152	874	4,175,833
4	1,041,550	215	206	1,189	1,142	1,100,522
5	757,560	143	189	822	1,085	848,434
6	5,183,638	947	183	5,078	980	4,354,716
7	2,478,614	401	162	2,289	923	2,004,240
8	2,252,457	571	254	3,380	1,501	2,247,826
9	539,272	110	204	537	996	593,621
10	751,824	260	346	1,269	1,688	1,062,066
11	1,893,913	453	239	3,141	1,658	2,074,295
<b>Totals</b>	<b>22,158,126</b>	<b>4,323</b>	<b>195</b>	<b>24,239</b>	<b>1,094</b>	<b>\$ 19,800,630</b>

\* As of 11/05/04, ASKIT.

## Kidney Health Care

### Facility Information by Region

The Kidney Health Care Act of 1973 authorized the Kidney Health Care Program to enter into agreements and contracts to provide for payment of services to carry out the intent of the Act (Texas Health and Safety Code, Chapter 42, Section 3-12).

To be a KHC approved provider, the facility must be licensed by DSHS, be approved by Medicare and Medicaid, and agree to the KHC agreement terms.

The table below reflects the number of KHC outpatient dialysis facilities and transplant centers, along with the number of dialysis stations available per Public Health Region, and if CAPD and CCPD are provided. Additionally, the number of applicants and eligible program recipients as reported by facility patient census is reflected.

KHC has agreements with approximately 660 providers, including outpatient dialysis facilities, hospitals, transplant hospitals, and physicians. KHC only accepts patient applications from outpatient facilities and hospital providers.

### Regional Provider Information

Region Totals	Facility Count	Out-pt. Dialysis Stations	Trans-plant Center	CAPD* Available	CCPD† Available	FY04 Applicants	KHC Eligible Recipients
Region 1	11	335	1	5	5	174	864
Region 2	5	129	0	1	0	94	491
Region 3	63	1,683	9	12	11	955	5,152
Region 4	21	448	1	3	2	215	1,189
Region 5	18	383	0	4	3	143	822
Region 6	78	1,963	5	22	26	947	5,078
Region 7	29	923	2	6	4	401	2,289
Region 8	52	1,094	3	6	4	571	3,380
Region 9	6	187	0	0	0	110	537
Region 10	11	367	1	6	6	260	1,269
Region 11	39	958	0	11	10	453	3,141
Out of State	2	104	1	0	0	0	27
<b>Total</b>	<b>335</b>	<b>8,574</b>	<b>23</b>	<b>76</b>	<b>71</b>	<b>4,323</b>	<b>24,239</b>

\* Continuous Ambulatory Peritoneal Dialysis

† Continuous Cycling Peritoneal Dialysis

‡ Data reflects actual patient census per facility and not by patient county or region of residence as indicated on regional maps.



**KHC Mortality Data**

This section focuses on mortality data for the KHC incident dialysis population (hemodialysis, CAPD, and CCPD) by age, ethnicity, and primary diagnosis. In FY01, the methodology for calculating mortality data was changed. Dialytic applicants are now categorized by the calendar year of first dialysis treatment and by year of reported death for years one through three. Years two and three are cumulative numbers. No adjustments for age, race, sex, diagnosis characteristics, co-morbid conditions, and disease severity were made to this data.

As Table 33 shows, 1,094 African American applicants were approved for benefits in calendar year 1999. Of this number, 100 deaths were reported to KHC within the first year of treatment - a crude mortality rate of 9.1%. By the end of year two, the mortality rate had more than doubled, to 19.8%, and by the end of year three, the mortality rate increased to 30.4%.

For KHC, it is important to note that while the number of applicants is higher in the Hispanic group for all years being reported, the mortality rate for the White group is highest for all three years being reported. As noted in the United States Renal Data System 2004 Annual Data Report, White patients are least likely to survive five years after initiating ESRD therapy, as compared to Hispanics and patients of other ethnicities, which for KHC, could be due to the later age of onset within the White group.

Lower mortality rates for the newest ESRD patients are consistent with improvements in patient survival, while the increased rate for patients who have been on the program longer shows the need for greater attention to factors that develop over time, such as abnormalities in mineral calcification, lipid disorders, and diabetic and cardiovascular complications (United States Renal Data System, 2003 Annual Data Report).

**Table 33: Mortality by Ethnic Group & 1st Date of Dialysis**

<b>Ethnic Group</b>	<b>1<sup>st</sup> Date of Dialysis Calendar Year</b>	<b># Applicants</b>	<b># Deaths by End of 1<sup>st</sup> Year</b>	<b>Mortality Rate</b>	<b># Deaths by End of 2<sup>nd</sup> Year</b>	<b>Mortality Rate</b>	<b># Deaths by End of 3<sup>rd</sup> Year</b>	<b>Mortality Rate</b>
African American	1999	1,094	100	9.1%	217	19.8%	333	30.4%
	2000	1,021	110	10.8%	246	24.1%	335	32.8%
	2001	1,120	105	9.4%	230	20.5%	320	28.6%
	2002	1,117	106	9.5%	200	17.9%		
	2003	988	97	9.8%				
Hispanic	1999	1,638	186	11.4%	374	22.8%	550	33.6%
	2000	1,740	170	9.8%	346	19.9%	535	30.7%
	2001	1,770	206	11.6%	404	22.8%	572	32.3%
	2002	1,815	184	10.1%	357	19.7%		
	2003	1,736	171	9.9%				
White	1999	1,157	221	19.1%	420	36.3%	561	48.5%
	2000	1,052	174	16.5%	337	32.0%	465	44.2%
	2001	1,151	202	17.5%	385	33.4%	522	45.4%
	2002	1,133	204	18.0%	358	31.6%		
	2003	1,006	159	15.8%				
Other	1999	73	8	11.0%	16	21.9%	22	30.1%
	2000	92	12	13.0%	23	25.0%	33	35.9%
	2001	74	3	4.1%	11	14.9%	17	23.0%
	2002	57	7	12.3%	11	19.3%		
	2003	91	9	9.9%				

*As of 11/12/04, ASKIT.*

Table 34: Mortality by Primary Diagnosis &amp; 1st Date of Dialysis

Primary Diagnosis	1 <sup>st</sup> Date of Dialysis Calendar Year	# Applicants	# Deaths by End of 1 <sup>st</sup> Year	Mortality Rate	# Deaths by End of 2 <sup>nd</sup> Year	Mortality Rate	# Deaths by End of 3 <sup>rd</sup> Year	Mortality Rate
Diabetes	1999	2,254	278	12.3%	579	25.7%	848	37.6%
	2000	2,302	263	11.4%	555	24.1%	823	35.8%
	2001	2,350	295	12.6%	596	25.4%	823	35.0%
	2002	2,350	239	10.2%	506	21.5%		
	2003	2,160	227	10.5%				
Hypertension	1999	912	117	12.8%	232	25.4%	341	37.4%
	2000	922	113	12.3%	228	24.7%	310	33.6%
	2001	996	122	12.2%	247	24.8%	343	34.4%
	2002	954	145	15.2%	228	23.9%		
	2003	931	93	10.0%				
Glomerulonephritis	1999	304	41	13.5%	72	23.7%	97	31.9%
	2000	246	28	11.4%	46	18.7%	72	29.3%
	2001	242	26	10.7%	50	20.7%	67	27.7%
	2002	261	25	9.6%	44	16.9%		
	2003	254	32	12.6%				
Other	1999	492	79	16.1%	144	29.3%	180	36.6%
	2000	435	61	14.0%	122	28.0%	161	37.0%
	2001	527	73	13.9%	137	26.0%	186	35.3%
	2002	557	92	16.5%	144	25.9%		
	2003	476	65	13.7%				

As of 11/12/04, ASKIT.

Table 34 reports on KHC mortality by primary diagnosis. Of those diabetic applicants who entered the program in calendar year 1999, 12.3% had died within the first year of treatment; however, by the end of the second year of treatment, the mortality rate had more than doubled, and by the end of the third year of treatment, the mortality rate had increased to 37.6%.

For all years being reported, the diabetic group has the highest number of patient deaths. It is likely that the high mortality seen in this group of applicants is due to the long-term and serious complications associated with the burden of diabetes, particularly, the burden of cardiovascular disease within the KHC patient population.

When comparing applicants with a primary diagnosis of diabetes to those with a primary diagnosis of hypertension, mortality rates are fairly similar in the first and second years of treatment; however, when looking at third year death rates for these two groups, the mortality rate for diabetics surpasses the rate of those patients with hypertension.

Mortality rates for any group can be affected by multiple factors, such as age of entry into the program, primary diagnosis, disease severity, and other co-morbid conditions.

Table 35: Mortality by Age Group & 1st Date of Dialysis

Age Group	1 <sup>st</sup> Date of Dialysis Calendar Year	# Applicants	# Deaths by End of 1 <sup>st</sup> Year	Mortality Rate	# Deaths by End of 2 <sup>nd</sup> Year	Mortality Rate	# Deaths by End of 3 <sup>rd</sup> Year	Mortality Rate
0-20	1999	26	3	11.5%	4	15.4%	5	19.2%
	2000	28	0	0.0%	0	0.0%	0	0.0%
	2001	25	0	0.0%	0	0.0%	0	0.0%
	2002	12	0	0.0%	0	0.0%		
	2003	25	0	0.0%				
21-34	1999	179	12	6.7%	31	17.3%	38	21.2%
	2000	201	14	7.0%	28	13.9%	39	19.4%
	2001	231	12	5.2%	31	13.4%	46	19.9%
	2002	244	14	5.7%	23	9.4%		
	2003	227	16	7.0%				
35-44	1999	379	30	7.9%	62	16.4%	99	26.1%
	2000	358	22	6.1%	55	15.4%	77	21.5%
	2001	388	28	7.2%	51	13.1%	78	20.1%
	2002	412	29	7.0%	57	13.8%		
	2003	400	22	5.5%				
45-54	1999	738	68	9.2%	137	18.6%	215	29.1%
	2000	790	57	7.2%	139	17.6%	201	25.4%
	2001	805	63	7.8%	138	17.1%	205	25.5%
	2002	825	63	7.6%	126	15.3%		
	2003	820	64	7.8%				
55-64	1999	977	108	11.1%	211	21.6%	312	31.9%
	2000	960	104	10.8%	201	20.9%	304	31.7%
	2001	1045	128	12.2%	240	23.0%	347	33.2%
	2002	1037	103	9.9%	215	20.7%		
	2003	1009	95	9.4%				
65-74	1999	1052	152	14.4%	317	30.1%	449	42.7%
	2000	941	139	14.8%	265	28.2%	393	41.8%
	2001	1022	151	14.8%	317	31.0%	429	42.0%
	2002	930	141	15.2%	238	25.6%		
	2003	817	119	14.6%				
75+	1999	611	142	23.2%	265	43.4%	348	57.0%
	2000	627	130	20.7%	264	42.1%	354	56.5%
	2001	599	134	22.4%	253	42.2%	326	54.4%
	2002	662	151	22.8%	267	40.3%		
	2003	523	120	22.9%				

As of 11/12/04, ASKIT.

Table 35 shows that as age increases, so does mortality, and for KHC applicants, the 75+ age group has the highest mortality rate for all years being reported. Increasing age is usually associated with higher mortality, regardless of gender, ethnicity,

or primary diagnosis. The burden of cardiovascular disease seen in older patients is possibly one of many contributing factors to the high mortality rates seen in this patient population.

## Contacting the Kidney Health Care Program

### Mail

Mail Code: 1938  
Department ID: G31000  
Department of State  
Health Services (DSHS)  
Purchased Health Services Unit  
Kidney Health Care Program  
1100 West 49th Street  
Austin, Texas 78756-3184

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### Internet

[www.dshs.state.tx.us/kidney/default.shtm](http://www.dshs.state.tx.us/kidney/default.shtm)

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### Phone

(512) 458-7150

### Fax

(512) 458-7162

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### KHC 1-800 Number

**1-800-222-3986 (Outside Austin)**  
**458-7150 (in Austin)**

The KHC 1-800 number connects you to an Information Resource Specialist who can assist you with questions regarding claims and eligibility information. KHC staff can also be contacted using this number during normal business hours. Bilingual (English/Spanish) staff are available.

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### Telecommunications Device for the Deaf (TDD)

(800) 735-2989 - Relay Texas, TTY  
or  
Speech Disability Phone Access "711"

## Obtaining Information About Kidney Disease

American Kidney Fund  
6110 Executive Blvd., Ste. 1010  
Rockville, Maryland 20852  
(800) 638-8299 <http://www.akfinc.org>

American Association of Kidney Patients  
3505 E. Frontage Rd., Ste. 315  
Tampa, Florida 33607  
(800) 749-2257 <http://www.aakp.org/>

ESRD Network of Texas (#14)  
14114 Dallas Parkway, Ste. 660  
Dallas, Texas 75254  
(972) 503-3215  
<http://www.esrdnetwork.org/>

National Institute of Diabetes & Digestive & Kidney Diseases  
NIDDK, NIH, Building 31, Room 9A04  
Center Drive, MSC 2560  
Bethesda, MD 20892-2560  
(301) 654-4415  
<http://www.niddk.nih.gov>

National Kidney Foundation, Inc.  
30 East 33rd Street, Ste. 1100  
New York, NY 10016 (800) 622-9010  
<http://www.kidney.org>

### Kidney Health Care Forms

Application for Benefits and Instructions  
Recipient Travel Claim Form

### Other KHC Information

KHC Rules  
KHC Benefit Summary  
KHC Annual Report