Transforming Care for Patients and Providers
Perspective from Nonprofit Providers

Suzanne Watnick[1,2] *and Jeffrey Silberzweig*[3,4]

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Introduction

On July 10th, 2019, we watched the President sign Executive Order #13879, "Advancing American Kidney Health" (AAKH) (1). The Department of Health and Human Services (HHS) Secretary Alex Azar stated: "Decades of paying for sickness and procedures in kidney care, rather than paying for health. . .has produced less-than-satisfactory outcomes at tremendous cost. Through new payment models and many other actions. . ., (we will) deliver Americans better kidney health, more kidney treatment options, and more transplants" (2). We welcome this unprecedented attention to the health of our patients.

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These proposals represent the most sweeping and influential changes for people with kidney disease in the United States since the Medicare entitlement for dialysis in October 1972. The time to transform kidney care is overdue. In the 1960s, innovators developed life-sustaining treatments (3). Fifty years later, the technology has changed little. Patients remain tethered to machines, more frequently in centers than at home. Many patients start dialysis without education about treatment options. Some do not have information to identify their disease early enough or slow its progression. Rather than "Liv(ing) the life (they) were meant to live" (B. Peckham, personal communication), many neither experience the quality of life that they desire nor survive as they previously anticipated. The administration aims for a disruptive approach to improve care for patients with kidney disease. However, the path remains unclear and will be the work of our community for years to come.

As Chief Medical Officers of not-for-profit organizations, we often find ourselves addressing the needs of many stakeholders, focusing on patient care as our central mission and figuring how to achieve this with resources available. Along with our nephrologist colleagues and our dialysis organizations' leadership and staff, we seek to provide the best possible care for our patients. This discussion will focus on the potential consequences of the AAKH initiative for our patients, nephrologists, and dialysis organizations.

Upstream CKD Care

If screening and educational initiatives are successful, the largest number of people affected by the proposed changes would be the one in seven United States adults with CKD (4). CKD education and management programs improve medication adherence, slow progression, and improve outcomes for patients as they transition to ESKD, including higher rates of preemptive transplantation and home dialysis, with better preparation for dialysis (5).

Nephrologists will play a critical role. By participating in voluntary models, they can drive aggressive CKD treatment, foster partnerships with Primary Care Providers to slow CKD progression, educate patients regarding treatment options, and advocate strongly for transplantation. Improving upstream care can also better manage symptoms and maximally defer dialysis initiation. These models should provide additional incentives for nephrologists to care for patients with remaining kidney function in addition to caring for those without it. Payments for late-stage CKD must adequately reimburse physicians to provide care beyond "as usual." Details of these voluntary models are not yet available; we will see how incentives align.

The new models create laudable incentives to decrease silos around kidney care; dialysis organizations will be critical stakeholders. In addition to educating patients about treatment options, organizations can provide ongoing care with access to nursing and social service resources. Patients with improved knowledge are, for example, better prepared to evaluate home therapies. Organizations can work more closely with physician partners so that patients have resources upstream to dialysis initiation, preemptive transplantation, or other supportive pathways, such as medical management without dialysis.

Dialysis Care

On the basis of preferences of patients and nephrologists, the administration voiced its strong support for increases in home dialysis and kidney transplantation, driving payment by improving hard outcomes. The administration's stated goal of 80% of patients initiating kidney replacement therapy at home or *via* preemptive transplantation is unrealistic because of staffing resources, supply chain, and available organs,

[1]Northwest Kidney Centers, Seattle, Washington; [2]Department of Medicine, University of Washington, Seattle, Washington; [3]Rogosin Institute, New York, New York; and [4]Department of Medicine, Weill-Cornell School of Medicine, New York, New York

Correspondence: Dr. Suzanne Watnick, Northwest Kidney Centers, University of Washington, 700 Broadway, Seattle, WA 98122. Email: swatnick@uw.edu

but there is wide latitude to improve on current incident United States peritoneal and home hemodialysis rates of 9.8% and 1.7%, respectively (4). Doubling total rates of home dialysis (to 23%) by the model's end would be remarkable but still not achieve the AAKH goal.

The voluntary models that include either nephrologists or nephrologists paired with other stakeholders will provide care for patients throughout the spectrum of kidney disease. Presumably, these could closely resemble the partnerships formed in the ESKD Seamless Care Organization model. Bundled payments in new models should be equivalent for peritoneal dialysis and hemodialysis to incentivize home treatment options. The proposed mandatory model randomizes 50% of Medicare beneficiaries *via* hospital referral regions to care that is paid on the basis of transplant and home dialysis rates still subject to the Quality Incentive Program but not additional quality parameters.

Patients will not have the choice to participate in this nationwide cluster randomized trial. The model offers patients improved education and easier pathways to pursue home dialysis and transplantation. Yet, patients who are less likely to receive either (*e.g.*, those experiencing housing instability or socioeconomic hardship, those in inner city or rural areas, or those with minimal support for transplantation) risk being "lemon dropped" by dialysis organizations. For example, in New York City, the rent that affords 500 square feet, which may be untenable for home dialysis, might afford a two-bedroom house elsewhere. In rural areas, access to transplant centers may be difficult. Proposed payment cuts as steep as 13% may force facility closures, leaving patients with few care options. With "rolling benchmarks," facilities need to perform better each year for similar payment. Government actuaries predicted net $169 million negative to the field (6). Such cuts may affect our most vulnerable patients, leading to decreased access to care and further consolidation of the industry. Smaller dialysis organizations may be located within a single hospital referral region, and therefore, the entire organization might be randomized to the mandatory model. If their population cannot shift to higher rates of home dialysis, the organization might be at risk. Safeguards must be introduced to maintain options for our more vulnerable patients.

For the mandatory model to achieve its goal of increasing home dialysis rates, additional infrastructure, such as appropriately trained experienced nursing and support staff, adequate supply chain of dialysis materials, and delivery capabilities, must be available. In 2015, when a single company was unable to support growth in peritoneal dialysis, growth rates for the industry plateaued, and they have only minimally recovered (7). If companies build new capacity for growth and demand increases, costs may increase too.

In the proposed models, nephrologists can captain these changes. We can be the driving force for referrals to appropriate modalities. Although some countries support home dialysis rates upward of 80%, the literature from North America suggests a 'right size' closer to 25%–50% (8,9). In a field where some nephrologists have felt marginalized over time, leading to substantial dissatisfaction, this initiative could drive nephrologists to reclaim a central place in care delivery. Partnerships between nephrologists, patients, and dialysis organizations will be critical to optimize the system with these comprehensive models.

Kidney Transplantation

For people with ESKD who are candidates, kidney transplantation is often the optimal choice. Patients may celebrate that the administration aims to increase the donor organ supply, for example, by decreasing the discard rate and supporting kidney donors. Organ procurement agencies may have new external monitoring goals to drive outcomes, which may change recipient selection. If partnerships are formed and criteria for transplantation are relaxed, transplant waitlists may grow depending on availability of additional organs.

With the proposed voluntary models, nephrologists but not dialysis organizations will be financially incented to perform preemptive transplants. Nephrologists will get substantial bonuses over the first 3 years after patients are transplanted—$15,000—if the patient and transplanted organ remain relatively healthy. Such strong financial incentives must be balanced with appropriate clinical scenarios, ensuring that nephrologists are referring the right patients at the right time. The proposed mandatory models may foster stronger relationships with transplant centers. Many transplant teams are partnered with large hospital systems, and limitations within that system must be considered. One concern may be a larger number of borderline candidates and organs accepted for transplantation, which may not remain functional for extended periods.

The current system has built and reinforced siloes for decades; crossing these siloes, creating new relationships, and invigorating existing relationships will take time to institute in a meaningful way. We do not know how this will play out. We celebrate the AAKH objectives to increase home dialysis and kidney transplantation, better coordinate CKD care, and create opportunity for innovation. As nonprofit providers, this aligns with our goals to provide the right therapies for the right patient at the right time. However, the proposed changes are disruptive, which was the intention of the HHS. We hope that this disruption will ultimately provide better health and quality of life for our patients rather than fewer choices and a wider chasm of experience for those patients who have resources and those who do not. Who will weather these disruptive proposals? Those with greater resources and those more versatile to change. What opportunities will become apparent to benefit those with kidney disease? Clearly, patients, nephrologists, and dialysis organizations need to work closely to navigate these waters, helping patients to transition smoothly and land softly in this new paradigm of care.

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Disclosures

Dr. Watnick is the Chief Medical Officer of Northwest Kidney Centers. Dr. Watnick is also a member of the ASN Policy and Advocacy Committee and an advisor to Cricket Health, Inc.

Dr. Silberzweig is the Chief Medical Officer of Rogosin Institute and serves as a consultant for Bayer Pharmaceuticals and Alkahest Pharmaceuticals, outside the submitted work.

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