Integrated Care for People with Kidney Disease
The Perspective of a Nonprofit Dialysis Provider

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Patient care in advanced CKD and ESKD is fragmented; it misses many opportunities to improve patient experience of care and population health as well as to reduce cost. Integrated care should treat patients with CKD as individuals with important current clinical needs, not just as people who may someday be treated by dialysis or kidney transplantation. When the illness trajectory suggests that uremia may become a real consideration, integrated care should reward timely and consequential patient and family education, including preemptive transplantation, home dialysis, and medical management without dialysis. Integrated care should preserve patient choice, and the care model should not unreasonably restrict providers’ access to the marketplace.

We recommend that proposals to integrate kidney disease care should (1) respond to patient preferences, (2) improve care, (3) decrease cost, (4) limit initial enrolment so as to contain unintended consequences, and (5) allow all providers of dialysis care, regardless of size, to participate independently.

We have previously set forth desiderata to improve CKD care (1). Such care should include BP control, improved management of diabetes, angiotensin system blockade in proteinuric kidney disease, management of hyperkalemia and metabolic acidosis, aggressive cardiovascular risk factor management, promotion of preemptive kidney transplantation, home dialysis, access placement before uremia, and advance care planning, the last particularly for patients for whom dialysis can be anticipated to offer very limited benefit. Scrupulous attention to signs, symptoms and electrolytes, with visits as frequently as weekly, can allow safe delay of dialysis, freeing patients from premature treatment and society of the financial burden of using the dialysis facility as a clinical safety net.

At least three integrated care alternatives to traditional Medicare and Medicare Advantage plans for patients on dialysis have been proposed: the ESRD Seamless Care Organizations (ESCOs) established by the Center for Medicare and Medicaid Innovation (CMMI) Comprehensive ESRD Care program (2), programs established under the proposed Dialysis Patients Act (3), and programs proposed under the Renal Physicians Association Incident ESRD Clinical Episode Payment Model (RPA Model) (4). All of these proposals can be expected to promote home dialysis and internal vascular access. All can create indirect incentives to coordinate CKD care, reduce costs, and improve kidney failure outcomes. None currently comprise measures to slow CKD progression or delay the start of kidney replacement therapy. The RPA Model offers the nephrologist financial incentives for transplantation. These incentives are a good start, but should be larger to reflect the patient benefit and decrease in cost associated with transplantation. However, all of these programs also perpetuate the current financial incentive to physicians and dialysis providers to start patients on dialysis rather than delaying or avoiding it. In addition, both the National Kidney Foundation (NKF) (5) and the American Society of Nephrology (ASN) (6) have proposed programs to improve kidney care. We are pleased that these organizations are taking a new approach to CKD, addressing care along the continuum rather than ESKD alone.

The important differences among these models are not clinical. Two already comprise CKD care; the other three could be expanded to do so. The models that do not explicitly address access to transplantation, the most important current limitation in ESKD treatment, could also be revised. The important differences among these models involve logistics, policy, and whether the model is designed to optimize patient care improvement or financial return to providers.

The two models most likely to influence care over the next few years are the CMMI ESCO program because of its successful track record and the Dialysis Patients Act. The Dialysis Patients Act advocates argue that the ESCO model will be unattractive to physicians and small organizations, because it requires them to assume risk, and that programs established under the Dialysis Patients Act will be more scalable. This argument about scale mistakes a feature of the ESCO program for a bug: the program represents major change in care of a vulnerable population; the CMMI is intentionally proceeding deliberately so as not to put patients at risk. The ESCOs will be unattractive to small organizations? Four of the 13 first round ESCOs were organized by smaller organizations, and currently, five small organizations run ten ESCOs. The argument that the program is unattractive because of the requirement to assume risk is better directed at the Dialysis Patients Act, under which dialysis providers must become insurers, assuming full risk. Small providers will not have access to the capital

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to allow them to compete with the largest dialysis providers under the Dialysis Patients Act. That, one fears, is a feature of the Dialysis Patients Act, not a bug.

It must be said civilly but clearly that the stakes are money, control, and possibly, the future of kidney care in the United States. No convincing clinical or public health objection has been offered to the ESCO model, only references to scalability and sustainability. Two providers now treat >70% of dialysis patients in the United States; a model designed to improve care should not promote further consolidation. The difference between ESCOs and plans established under the Dialysis Patients Act is that, under the latter, only the largest organizations would have the capital to act as insurers.

We worry that the Dialysis Patients Act, as currently written, could lead to further consolidation of dialysis care. Would that be undesirable? The US Renal Data System found a nonprofit dialysis provider’s mortality and hospitalization rates to be lower than those of the two large for-profit providers from 2003 to 2014 and then stopped comparing. A multivariable analysis found that “for-profit ownership of dialysis facilities, as compared with not-for-profit ownership, is associated with increased mortality and decreased rates of placement on the waiting list for a renal transplant” (7). The difference was attenuated by the presence of a nonprofit in the same county as the for-profit unit: competition is good. Recent analyses have found lower hospitalization rates, better patient experience of care, and the perception by nurses that there is a stronger culture of safety at nonprofit dialysis facilities (8,9). We work for a nonprofit provider, and it is difficult for us to be objective about the differences between for-profit and not-for-profit care. However, these findings certainly suggest that there is a public interest in preserving nonprofit care as an alternative. We also believe that it is beneficial for small providers to continue to care for people with kidney disease so that a wider range of approaches to care can be implemented and patients can have a choice of provider.

The Dialysis Patients Act is styled as a provider-neutral demonstration, but one advocate described it as “our patient demonstration legislation, wherein we would pick up the right to put thousands and thousands and thousands of our patients into a globally capitated environment” (10). This legislation would yield far more than a demonstration: it would lead to a complete change in the care of patient on dialysis in the United States. Additionally, we are concerned that its effects will not be provider neutral. The dialysis providers who contemplate acting as insurance companies would not be required to meet Medicare Advantage plan safeguards. In the first year, they would be operating a capitated model in an open network, an almost impossible feat. Would they be required to pay on time as Medicare does? In their closed network, all providers must be contracted. A patient could sign up for this closed network and discover later that her nephrologist, primary care provider, cardiologist, and hospital are not contracted providers. Plans established under the Dialysis Patients Act might not allow independent nephrologists and other providers to both remain independent and participate in a closed network.

The ESCO program is far from perfect. However, it has achieved shared savings without sacrificing quality, and it shows promise to improve care. The CMMI should expand the ESCOs to include stage 4 and 5 CKD, provide financial incentives for transplantation, allow new ESCOs to form, and add a capitation payment track to the ESCO program using the full Medicare Advantage rate. As they gain experience, providers could progress from one-sided risk to two-sided risk to capitation. The ESCO framework requires local governance and does not allow a dialysis provider to occupy more than one half of the seats on the ESCO board.

The ESCO model thus protects patients, nephrologists, and small providers, both for profit and nonprofit. Proposals such as the NKF, ASN, and RPA Models, deserve serious consideration. The Dialysis Patients Act, as currently written, is a bad idea. We hope that it will be revised to add Medicare Advantage safeguards; to limit program size; to allow open networks only; to make it possible for small providers to establish independent programs; to support improved care before CKD causes uremia; to replace the current incentive to initiate dialysis with incentives to delay dialysis and promote transplantation; and to improve advance care planning. However we choose, we must remember, with Francis Weld Peabody, that “the secret of the care of the patient is in caring for the patient.” Medicine is not a business.

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