Perspective

CJASN ePress. Published on July 9, 2020 as doi: 10.2215/CJN.04660420

Stepping into the Void

Remunerating, Valuing, and Understanding Nephrologists

Anupam Agarwal[1] *and Tod Ibrahim*[2]

CJASN 15: ●●●–●●●, 2020. doi: https://doi.org/10.2215/CJN.04660420

[1]Division of Nephrology, University of Alabama at Birmingham, Birmingham, Alabama
[2]American Society of Nephrology, Washington, DC

Correspondence: Mr. Tod Ibrahim, American Society of Nephrology, 1401 H Street NW, Washington, DC 20005. Email: tibrahim@asn-online.org

In "Understanding Work: Moving Beyond the RVU," Rosner and Falk (1) ask kidney organizations, policy makers, and health systems to help transform a "fundamentally flawed" approach to physician compensation. Under the current system, essential care for people with kidney disease is neither adequately valued nor compensated. Rosner and Falk (1) challenge kidney organizations "to step into this void" and transform how the value of the work nephrologists do is calculated and remunerated. As President and Executive Vice President of the American Society of Nephrology (ASN), we pledge that the society will answer that call.

Kidney disease is the ninth-leading cause of death in the United States; an estimated 37 million Americans have kidney disease, >764,000 have kidney failure (2), and nearly 100,000 Americans are on the waiting list to receive a kidney transplant (3). People with kidney disease receive care and a better quality of life because of the complex, technically advanced, and lifesaving care kidney professionals provide, despite the faulty system Rosner and Falk (1) describe. This gap between the complexity of care and the reality of compensation exists even though the Medicare program spends >$120 billion annually on care for people with kidney disease or kidney failure (representing one third of total Medicare fee-for-service spending) (3).

Why doesn't the current system work?

Since 1992, the Centers for Medicare and Medicaid Services (CMS) and most payers use the resource-based relative value scale to pay physicians in the United States. To determine payments for physician services, the CMS uses a physician fee schedule on the basis of the relative value units (RVUs) for each service. These payments are determined by a formula that estimates the costs needed to provide them, with each service divided into three categories.

1. Physician work relative value units (wRVUs) account for the time, effort and technical skill, judgment and mental energy, and stress to provide a service.
2. Practice expense RVUs focus on the clinical and nonclinical efforts of the practice by nonphysicians, as well as expenses for space, equipment, and supplies.
3. Professional liability insurance RVUs address the cost of malpractice insurance premiums.

Nephrology is cognitive and procedural, has a primary care component focused on identifying patients and slowing progression of kidney disease, and includes the need to manage comorbidities. Nephrologists also provide 24-hour coverage—often for dialysis services for critically ill patients—an important service to health systems. However, the pay scale for nephrologists is markedly less than other specialties, such as cardiology, and is more aligned with cognitive specialties that often do not have to provide 24-hour emergency call. The compensation for the perceived workload has, therefore, negatively affected interest in nephrology careers.

The specialty of cardiology provides a useful comparison with nephrology. Cardiology evolved from cardiovascular disease, first certified by the American Board of Internal Medicine (ABIM) in 1941, into cardiovascular disease and four subspecialties: clinical cardiac electrophysiology (first certified in 1992), interventional cardiology (1999), advanced heart failure and transplant cardiology (2010), and adult congenital heart disease (2015). Each of these subspecialties has its own wRVUs.

The ABIM first certified nephrologists in 1972, so the specialty is today where cardiology was in the early 1990s when the ABIM started to recognize subspecialization in that specialty. After 50 years, nephrology is ready for subspecialization, and cardiology provides a potential model to develop wRVUs for each of the potential subspecialties within nephrology, such as

- general nephrology (including cardiorenal disease, hypertension, diabetic kidney disease, and glomerular diseases, such as polycystic kidney disease);
- critical care nephrology and AKI;
- dialysis care (including in-center and home modalities);
- interventional nephrology;
- onconephrology; and
- transplant nephrology.

In addition to building a structure for subspecialties, nephrology must address fundamental challenges to its future viability. Nephrology must shift the focus from treating kidney failure to improving kidney health, spur innovation, increase the rate of kidney transplants, and generate interest among diverse groups of students and trainees. More broadly, US health care faces external threats. These risks exist in the professional ecosystem (health system integration, employed physicians, and private equity), professional

demands (value-based care, electronic health records, and maintenance of certification), and personal anxiety (work-life balance, debt, and burnout). The coronavirus disease 2019 pandemic will exacerbate these vulnerabilities, particularly for frontline physicians like nephrologists.

The ASN has initiated programs to help address these challenges, but transforming nephrology also requires tackling the significant obstacle Rosner and Falk (1) highlight. The RVU system "requires dramatic reform that aligns payment with performance and more clearly values the time and effort required to provide high-quality patient care" (1). Addressing the RVU system will help ensure that all patients with kidney disease in the United States receive care from the experts who can improve their quality of life.

The RVU compensation system has improved through sustained efforts of groups like the Renal Physicians Association. However, flaws disproportionately affect highly cognitive specialties like nephrology, and future opportunities and challenges require the kidney community to accept the directive from Rosner and Falk (1) and others to "move beyond" the RVU system and establish "meaningful metrics from and for all types of nephrology practices" (1). The wRVU is particularly problematic for nephrology.

Concerns specific to reimbursement for nephrologists echo a chorus of criticisms about RVUs (4). In 2015, the Government Accountability Office (GAO) issued a report —"Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy"—that should worry every taxpayer and activate every member of the kidney community (5).

The GAO found that the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC)—which is responsible for reviewing wRVUs for physician services in Medicare—"may not be accurate due to process and data-related weaknesses." According to the GAO, "some of RUC's survey data had low response rates, low total number of responses, and large ranges in responses, all of which may undermine the accuracy of the RUC's recommendations." The ASN commends the GAO's findings and urges the CMS to adopt the report's recommendations (Table 1).

External forces are also driving a re-evaluation of nephrology. Last year, the federal government launched the nation's first kidney health strategy that aims to reduce the number of Americans with kidney failure by 25% over the next decade (6). This mandate requires primary care to identify people at risk for kidney disease, help these individuals avoid kidney disease, and then refer these patients to nephrologists to slow disease progression.

The government also intends to double the number of kidneys available for transplant and provide more options to people with kidney failure, including a greater emphasis on home dialysis and the creation of a next-generation kidney. The first of these mandates requires restructuring every aspect of the transplant process, including legislative initiatives to increase the availability of kidneys from living donors and coverage for lifetime immunosuppressive drugs for people who receive transplants. The second mandate requires changes to the educational continuum in nephrology and huge investments in kidney research.

Recent studies have demonstrated that sodium glucose cotransporter 2 inhibitors reduce progression of kidney disease in patients with diabetes and albuminuria, increased our understanding of genetic factors that make so many people susceptible to diabetic kidney disease, and applied deep learning to predict AKI. The kidney community is starting to conquer regenerative medicine and determine if precision medicine will produce groundbreaking treatments for people with kidney disease. Clinical programs for specific kidney disease indications have changed dramatically in recent years. A decade ago, there were no clinical trials addressing nephrotic syndrome. Today, >20 clinical trials are in phase 2 or phase 3 (7).

The millions of Americans with kidney disease could benefit from these types of clinical and scientific advances, but only if nephrology becomes more attractive to future physicians, researchers, and other health professionals. The entire kidney community must rally together to address several challenges, including the reality that essential care for people with kidney disease is neither adequately valued nor compensated.

Through a newly established task force exploring nephrologist compensation and assessing nephrologist productivity, the ASN commits to improving the professional environment for nephrologists. Working with all interested stakeholders and societies that have successfully improved compensation approaches (8), the ASN will launch concrete, measurable, and transparent efforts to reduce bias in the data that feed physician compensation and productivity systems; provide data specific to all aspects of nephrology; increase the quantity and quality of data available to all nephrologists; and reflect the variety and complexity of care nephrologists provide today and in the future.

This commitment supports other ASN initiatives designed to articulate a vision for the specialty of nephrology during

Table 1. The Government Accountability Office recommendations to the Centers for Medicare and Medicaid Services

In "Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy," the Government Accountability Office (5) recommends that the Centers for Medicare and Medicaid Services
"Better document the process for establishing relative values for Medicare physicians' services, including the methods used to review RUC recommendations and the rationale for final relative value decisions"
"Develop a process for informing the public of potentially misvalued services identified by the RUC, as CMS already does for potentially misvalued services identified by CMS or other stakeholders"
"Incorporate data and expertise from physicians and other relevant stakeholders into the process as well as develop a timeline and plan for using the funds appropriated by [the Protecting Access to Medicare Act of 2014]"

RUC, Relative Value Scale Update Committee; CMS, Centers for Medicare and Medicaid Services.

the next decade. Furthermore, it advances the ASN's mission to diversify the field by ensuring that the next generation is attracted to careers in nephrology because it is remunerated, valued, and understood.

Acknowledgments

The content of this article does not reflect the views or opinions of the American Society of Nephrology (ASN) or *CJASN*. Responsibility for the information and views expressed therein lies entirely with the author(s). As noted in the "Disclosures" section below, A. Agarwal is ASN President and T. Ibrahim is an employee of the ASN (Executive Vice President).

Disclosures

A. Agarwal serves on the medical advisory boards of Akebia, Alpha Young LLC, Angion, Reata, and Dynamed. He also serves on the medical advisory board and has stock options for Goldilocks Therapeutics and is President of the ASN. T. Ibrahim is an employee of the ASN (Executive Vice President). He is also on the Council of Medical Specialty Societies (President) and the American Society of Microbiology (Member, Audit Committee).

Funding

None.

References

1. Rosner MH, Falk RJ: Understanding work moving beyond the RVU [published online ahead of print February 24, 2020]. *Clin J Am Soc Nephrol* doi:10.2215/CJN.12661019
2. Centers for Disease Control and Prevention: National Center for Health Statistics: Leading causes of death, 2017. Available at: https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm. Accessed April 8, 2020
3. United States Renal Data System: *2019 USRDS Annual Data Report: Epidemiology of Kidney Disease in the United States*, Bethesda, MD, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, 2019
4. Giacoma T, Ayvaci MUS, Gaston RS, Mejia A, Tanriover B: Transplant physician and surgeon compensation: A sample framework accounting for nonbillable and value-based work. *Am J Transplant* 20: 641–652, 2020
5. Cosgrove JC: Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy, Collingdale, PA, DIANE Publishing Company, 2015
6. United States Executive Office of the President [Donald J. Trump]: Executive Order 13,879: Advancing American Kidney Health, 10 July, 2019. *Fed Regist* 84: 33817–33819, 2019
7. Martz L: Kidney is the new liver: Why kidney indications are coming into sharp focus, *Biocentury*, October 7, 2019. Available at: https://www.biocentury.com/article/303526. Accessed April 8, 2020
8. Hollmann PA, Zorowitz RA, Lundebjerg NE, Goldstein AC, Lazaroff AE: Hard work, big changes: American Geriatrics Society efforts to improve payment for geriatrics care. *J Am Geriatr Soc* 66: 2059–2064, 2018

Published online ahead of print. Publication date available at www.cjasn.org.

See related perspective, "Understanding Work: Moving beyond the RVU," on pages xxx–xxx.