

Strategies for Value-Based Care

By Gurdev Singh, Lauren Ellenburg, and Rajiv Poduval

Value-based care (VBC) is the buzzword in healthcare today, and nephrology is not behind in this venture. The word evokes anxiety and fear in most, as it is usually equated with a push to reduce costs by deploying expensive infrastructure, which comes with significant regulatory burden. What really happens is that the payor (insurance entity) delegates a subset of the population to a risk-bearing entity (RE) that has the skill set and resources to improve the quality of care provided at a lower than historical cost by use of innovative care models and technology. The financial savings (or losses) are then shared by the payor and RE. The patients in the program benefit from better quality and lower out-of-pocket costs. The end result is a win-win-win for all stakeholders.

After a successful 5-year pilot of the End-Stage Renal Disease (ESRD) Seamless Care Organization (ESCO), the Centers for Medicare & Medicaid Innovation (CMMI) launched the next generation of nephrology VBC models—Kidney Care First (KCF) and Comprehensive Kidney Care Contracting (CKCC). Given that the Centers for Medicare & Medicaid Services (CMS) spends \$121 billion per year on chronic kidney disease (CKD) with \$84 billion going toward non-ESRD, it came as no surprise that these models expanded the population at risk by including CKD stages 4 and 5, correctly recognizing the need for intervention upstream to have a meaningful impact. Some payors are even experimenting with models that include CKD stage 3B.

Patient education and appropriate clinical interventions earlier in the course of disease are expected to slow the progression of CKD. At the same time, CMS recognized the need for the nephrologists to be the driver of these programs, aligning financial incentives. In a major shift from the ESCO pilot where the dialysis organizations created the RE, these new models task the nephrologist to launch the Kidney Contracting Entity (KCE), which mandates the inclusion of a transplant provider but makes the dialysis organization participation optional and by invitation only. In addition, the KCF models make it easier for the nephrologist to par-

ticipate in a risk-free environment, providing financial incentives linked to quality metrics. The CMMI models are a precursor to an industrywide phenomenon with private payors exploring similar options.

Nephrologists are multidisciplinary team leaders in the dialysis unit and now have the opportunity to lead in VBC models for kidney care. This can be a great opportunity for nephrology practices to meaningfully change how we provide care to our patients. The thought of taking a risk may scare many of us and inhibit our opportunity to lead and in the process not only lose our autonomy and relevance but also the potential financial rewards.

To be successful during this transformation, a private nephrology practice must remain nimble, agile, and devoted to an ideology of enhanced patient outcomes at reduced cost. There are three basic keys to success in this new world.

Alignment and density: Alignment with like-minded nephrologists and physician collaboration becomes integral to the establishment of market density. Market density is important to implement programs that will improve the ability to care for large populations of patients in an efficient manner. CMMI allows for practices to join together in the CKCC model, pooling resources and reaching the required minimum number of patients.

Analytics capabilities: The ability to achieve target outcomes requires leveraging clinical data sets obtained from electronic health records, along with claims data. Analysis, strategic planning, implementation, and tracking become pivotal next steps for successfully managing the population at risk. Choosing a data-analytics partner who can provide this capability is an important step. There are a handful of vendors, mostly new entrants since the launch of the nephrology risk models, that have the knowledge and expertise in the nephrology space. Some focus only on the data, some on the care coordination, or both, whereas others offer a full suite of infrastructure and services, including practice management.

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Infrastructure: The transition from fee-for-service (FFS) VBC does not require large capital outlay but does need a paradigm shift in how we think about providing care. A multidisciplinary approach with emphasis on patient education and engagement becomes the key to success. A nephrologist-led team of professionals is needed to perform the administrative tasks and implement operational best practices, clinical guidelines, and high-risk programs.

We truly believe that for the first time, nephrologists are in the driver's seat to lead the transformation of kidney care delivery. Although the ESCO focused only on ESRD patients, had high cost outlays, and did not align the financial incentive for the nephrologist, the new models represent a paradigm shift and provide up-front and risk-free financial incentives to the nephrologists who are linked to quality and outcomes. These include an increase in average reimbursement for CKD stages 4 and 5 patients from \$400 per year (based on four office visits) to \$800 per year (new capitated rate) (Figure 1), a kidney transplant bonus of \$15,000 over 3 years, and a 5% alternative payment model (APM) bonus with the Merit-Based Incentive Payment System (MIPS) exemption (Table 1). Moving to the next level, a shared savings model can bring additional financial incentives but comes with a two-sided risk of sharing in losses.

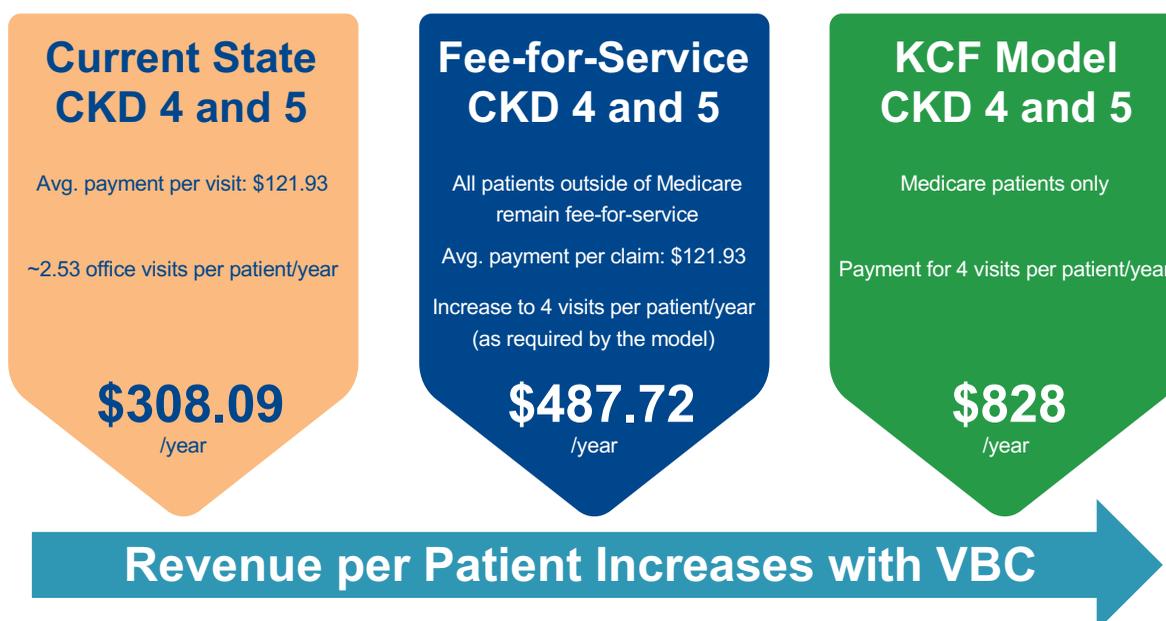
In conclusion, VBC models require us to think differently and provide an opportunity for the nephrologist to be the leader of transformation, but unlike history and prior models, this now represents a true investment in oneself. ■

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The authors are executives in Global Nephrology Solutions, which offers VBC services to the nephrologists. They have no other conflicts of interest.

Figure 1. Revenue per patient increases with value-based care

Comparison of Revenue per Patient per Year



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Table 1. Value-based care alignment

KCC components of reimbursement		
<p>CKD QCP</p> <p>Quarterly capitated payment (QCP) now received automatically with attribution</p>	<p>ESRD MCP</p> <p>ESRD payments continue to be reimbursed at traditional FFS</p>	<p>PD True-Up</p> <p>\$35 per patient per claim for home dialysis</p>
<p>KTB</p> <p>Each transplant completed receives \$15,000 over a 3-year period</p>	<p>5% APM</p> <p>Participation in Kidney Care Choices (KCC) qualifies as advanced APM, qualifying each practice for an automatic 5% increase on Medicare Part B payments</p>	<p>Shared savings</p> <p>50% shared savings split, comes with risk of shared losses</p>

MCP, monthly capitation payment; PD, peritoneal dialysis; KTB, kidney tuberculosis.

The Predicament of Establishing a Peritoneal Dialysis Program in a Nursing Facility

By Andrew E. Lazar

The case for more PD

According to the United States Renal Data System (USRDS)'s Annual Report for 2020, the number of incident patients with end stage kidney disease (ESKD) in 2018 was 131,636, which was an increase of 2.3% from the year prior (1). Although all-cause mortality increased among patients on dialysis in the first half of 2020 by 29% and 48% for those with a functioning kidney transplant compared with the same 5-week period in 2019 (2), overall mortality in patients with ESKD has trended downward, leading to an increase in prevalent patients on dialysis to a new high of 2042 cases per 1 million people in 2018 (1).

In 2018, there were 14,334 incident patients starting on peritoneal dialysis (PD), up from 10,865 in 2013. We should anticipate that PD prevalence in nursing facilities will increase for the following reasons: the incidence of ESKD in people aged 65–74 years old and 75+ years old reached an all-time high in 2018; PD incidence is on the rise; mortality from PD may be 0.88 for continuous ambulatory PD (CAPD) versus in-center hemodialysis based on the Australia and New Zealand Dialysis and Transplant (ANZDATA) registry (3); ESKD treatment choice (4) models incentivize use of home dialysis modalities; and the cost of PD was \$78,159 annually versus \$91,795 for in-center hemodialysis, again pushing the Centers for Medicare & Medicaid Services (CMS) to incentivize PD versus in-center hemodialysis (1).

Is consistent, high-quality PD care possible in a nursing facility environment?

In 2018, CMS released its rules on dialysis care in nursing facilities (5). The highlights of these regulations include the necessity for on-site supervision of dialysis by a trained registered nurse (RN) when a nursing home resident is receiving hemodialysis in the nursing facility and by a trained RN or licensed practical nurse (LPN) when PD is provided. In essence, the nursing facility's dialysis program is subject to the conditions for coverage and an updated ESKD core survey process (6).

I had the opportunity to interview some of the key providers of nursing home dialysis care as well as administrators of nursing facilities that have offered on-site PD. Scott Vavrinchik of Affiliated Dialysis (now Dialyze Direct) raised the concern for “keeping staff proficient to a level of standard of care that we are comfortable with,” as staff turnover tends to be an issue. Technical failure at a skilled nursing facility may increase peritonitis rates, an issue that should be studied more rigorously but has been reported anecdotally by providers. The space necessity for supplies is an issue at most sites.

From the financial perspective, it may not be feasible to send trained PD staff to do exchanges, necessitating the need for stable and trained staff at the skilled nursing facility to avoid technical failure with subsequent complications. Isaac

Lifschutz of Legacy Health Services, a provider of skilled nursing and assisted living services, cited nurse turnover rates as a major issue in providing consistent quality PD care at nursing facilities. According to researchers at the University of California, Los Angeles (UCLA), and Harvard Medical School (7), annual median turnover rates at nursing facilities were 94% in 2017 and in 2018, 141% among RNs.

“There's a very clear negative relationship between quality ratings and turnover,” said Ashvin Gandhi, PhD, economics, University of California, Los Angeles, in an interview with *McKnight's Long-Term Care News*. Lifschutz stated that residents, even if alert, may “disrupt their PD catheter, thus contaminating the site,” which requires significant oversight. Patients with kidney failure pose a particularly high readmission risk, which is a closely monitored and costly quality measure. Combined, these challenges make on-site PD a formidable challenge for both the nephrologist and nursing facility (Table 1). Indeed, Bellin et al. (9) recently characterized the skilled nursing facility ESKD patient population, suggesting increased mortality with advancing age and better survival with the provision of more frequent hemodialysis.

Nola McMullen of Renew Dialysis, a provider of home hemodialysis services in nursing home and rehab facilities, expressed the importance of maintaining best home dialysis practices for the skilled nursing facility patient while at the home. This should include “a partner helping with PD treatments while in the nursing home if willing.” Otherwise, McMullen stated, “The provider (PD program) is obligated to train the nursing home staff.” McMullen also said she felt that policies and procedures must be defined for the PD patient in a nursing facility environment to first contemplate whether PD remains the best modality choice and whether urgent-start patients are an option and to ensure that a “rigorous peritonitis prevention program” is in place.

The incidence of patients choosing PD as a preferred modality is continuing to grow. Moreover, the average age of patients who develop kidney failure is also increasing. Thus, the necessity to consider offering PD in the nursing facility is going to become a more pressing one. The challenges include logistics, staffing, and financial constraints that could be overcome with the development of a guideline for best practice and appropriate compensation by payers for both the home dialysis program and the nursing home provider. In essence, appropriate compensation could lead to more

Table 1. Benefits and barriers of PD in a nursing facility

Benefits	Barriers
Improved QOL for patients	Nursing facility staff turnover
Lower transportation costs	Quality-peritonitis risk
Fewer missed meals, medications, and therapies	Space requirements for PD equipment
May lower mortality and hospitalization rate (8)	Inadequate reimbursement
	Need for best practices guideline

QOL, quality of life.