Vascular Access and Dialysis Modality
Catheter Use, Health Differences Influence Morbidity in Hemodialysis vs. Peritoneal Dialysis

By Doug Kaufman

End stage renal disease (ESRD) patients receiving peritoneal dialysis (PD) usually have lower morbidity than hemodialysis (HD) patients, but other factors play a role as well.

The difference in morbidity could be partly due to the higher risk of early death among patients undergoing HD with central venous catheters (CVCs), according to a study in the June Journal of the American Society of Nephrology. In addition, “it may reflect the patients selected more than the process itself,” said lead author Jeffrey Perl, MD, a nephrologist at St. Michael’s Hospital and the University of Toronto School of Medicine, both in Toronto, Ontario.

Health differences among patients in past comparisons of PD and HD success rates make it difficult to declare one treatment better than the other, Perl said.

In this study, Perl looked at more than 38,500 Canadians starting dialysis between 2001 and 2008. The study took into account the various factors that come into play when the most effective type of dialysis is chosen.
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ACOs

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ACO are primary care providers (internal medicine, general medicine, family practice, and geriatric medicine) who provide a predefined set of primary care services. Although nephrologists and renal care providers may provide services to patients who are assigned to ACOs, CMS proposes that no specialists may form an ACO. Discussion of a potential option for a "renal-specific" ACO had been suggested by some in the kidney community, but CMS has strongly indicated that specialty-specific ACOs are not on the table at this time.

In the proposed rule, CMS recommended a number of approaches to improve the quality and reduce the cost of patient care, including promoting evidence-based medicine best practices, patient engagement, and surveying, reporting on cost and quality measures, coordination of care, and individualized care plans. While these approaches are all valuable steps to improving the quality of care, many of these key ACO care processes are already routinely undertaken in dialysis units in an ESRD-specific format and setting, as implemented by the Medicare ESRD Program. It is unclear how dialysis care would fit into an ACO model. ASN articulated concern that aligning the complex existing dialysis care system with a primary care-oriented ACO that uses quality metrics designed for the general population would be an extraordinarily complex task for dialysis units, the ACO, and nephrologists without adding value to individual kidney patients’ care. Subjecting dialysis patients to multiple sets of protocols, rules, and assignments by the ACO and the dialysis unit—could have an unintended negative influence on quality of care, leading to dual processes, conflicting care mandates, duplication of resources, and fragmented patient care.

CMS laid out 65 proposed quality metrics that ACOs must achieve to be eligible for shared savings. While potentially of great value to the general patient population receiving care in an ACO, many of the proposed quality metrics may not be appropriate for kidney patients. Yet CMS did not indicate that the quality measures may apply differently to dialysis or transplant patients. Nor did CMS provide any detail regarding case-mix adjustment of the quality measures to account for variation in patient populations. ASN commented that these omissions are problematic, and could create perverse incentives for an ACO to provide care appropriate only for the general population in order to meet the standards necessary to be eligible for shared savings—to the detriment of complex patients with kidney disease. According to Amy Williams, a member of the task force, “patients on dialysis simply have different care needs from the general patient population, and it was unclear based on CMS’ proposals that it would differentiate between the two groups. It is imminently possible that ACOs could be penalized for providing appropriate care to a patient on dialysis if that care led to an outcome divergent from the standards set for the general population.”

CMS proposes to assign beneficiaries to an ACO based on the primary care provider (PCP) from whom they receive a plurality (exact percent unspecified) of their primary care services (Table 1). ASN emphasized to CMS that many nephrologists serve as PCPs for their kidney patients, particularly those in late-stage CKD, those maintained on dialysis, and those who have received a recent transplant. To preserve this vital patient-nephrologist relationship and to prevent any unintended consequences for specialized patients in a primary care ACO, ASN recommended that dialysis patients and recent transplant recipients—populations who often receive the plurality of their care from a nephrologist—should not be attributed to an ACO.

This arrangement would permit patients with earlier stages of kidney disease to remain in the ACO and benefit from the coordinated care processes it facilitates, but, as indicated by their disease progression, eventually allow them to receive the specialized care they need—be it dialysis or transplantation—without affecting the ACO’s overall performance on the quality metrics.

Because care of patients with CKD, especially those with more advanced CKD, is extremely complex and requires close, multidisciplinary collaboration between the patient’s PCP and nephrologist as well as other physician and nonphysician providers in order to limit complications of the disease, including progression to kidney failure, ASN commented that ACOs may offer significant benefits for CKD patients, with some key modifications.

Processes that an ACO would facilitate—such as electronic patient data collection and sharing, quality monitoring, and individualized care plans, may lead to better outcomes and more patient-centered care for CKD patients. However, these outcomes will be open for comment) or an interim final issue either a final rule (which would not be open for comment) or an interim final rule (upon which CMS could solicit comment). ASN and the ACO Task Force will continue to follow CMS’ activities closely leading up to implementation of the program, and stand ready to help CMS further assess the effects of ACOs on the kidney patient population or to offer any additional guidance.

To read ASN’s comments to CMS on the ACO proposed rule, please visit the ASN Public Policy web page.

Having provided feedback to CMS on the proposed ACO rule, the ASN ACO Task Force will remain in place to address other aspects of new accountable care models. The task force is investigating the possibility of a potential CMS demonstration project on integrated care models for the CKD and ESRD populations. The task force will also continue to follow and respond to CMS’ next steps related to the proposed ACO rule.

Table 1. Key features of the ACO Proposed Rule

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<tr>
<th>Feature</th>
<th>Detail</th>
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<tr>
<td>Primary care focus</td>
<td>Only primary care providers (internal medicine, general medicine, family practice, and geriatric medicine) who provide the “plurality” of a specific set of primary care services may have patients assigned to the ACO in which they participate.</td>
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<td>Retrospective beneficiary assignment</td>
<td>Beneficiary assignment will occur after the end of the performance year, based on utilization data. ACOs might have to wait for up to 9 months after the end of the fiscal year to know who was actually “assigned” to their ACO.</td>
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<td>Quality measures</td>
<td>ACOs will report on 65 quality measures, in five domains, beginning in the first performance year of the program.</td>
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<td>Evidence-based medicine</td>
<td>The ACOs are required to implement evidence-based medicine or clinical practice guidelines and processes. All ACO participants and suppliers/providers must agree to abide by these guidelines and processes, and must be evaluated for their compliance.</td>
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<td>ACO risk models: one-sided model</td>
<td>Participants would be eligible to share in any cost savings associated with the program and would not be liable for any cost overruns. In the third year of participation, ACOs would undergo mandatory transition to the two-sided model.</td>
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<td>ACO risk models: two-sided model</td>
<td>Participating ACOs would receive a higher percentage of savings than participants in the two-sided model, however, ACOs in the two-sided model could be held responsible for costs that exceed certain benchmarks and could end up owing Medicare money.</td>
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<td>Patient choice</td>
<td>ACOs must notify patients that they are receiving care from providers that participate in an ACO. However, patients (and providers) will not know for sure whether the patient will be retroactively attributed to that ACO by CMS. Patients are free to seek care outside of the ACO from other providers.</td>
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<td>Electronic health records</td>
<td>At least 50 percent of the ACO participants must have Electronic Health Records and be “meaningful users,” by the start of the second year of participation in the ACO program.</td>
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