Likely Repeal of ACA Puts Coverage, Some Value-Based Initiatives in Limbo

The likely repeal of the Affordable Care Act (ACA) early in the Trump administration has placed patients who gained coverage through the legislation and the ACA's value-based kidney care initiatives in limbo.

The Trump administration and Republican leaders in Congress are vowing to quickly repeal the ACA when they take power in January 2017. The repeal is expected to allow a 2–3 year grace period for parts of the ACA to continue. After that time, Republicans are expected to replace the ACA with their own legislation.

The planned repeal raises many questions about what will happen to patients who gained coverage under the legislation, ACA programs for patients with kidney disease, and some of the patient protections in the bill.

Access to care

President Trump said shortly after the election that he would keep some protections, such as provisions that prevent individuals from being denied coverage based on preexisting conditions.

"From what I've seen, there seems to be a slight pulling back from a full repeal and all of its features," said Jeffrey Silberzweig, MD, chief medical officer at the Rogosin Institute. "I've always believed in a cautious approach to things, so I'm pleased to see that."

But John Sedor, MD, chair of the American Society of Nephrology's Public Policy Board and a nephrologist at MetroHealth System in Cleveland, is concerned that some of his patients who gained access to insurance through the ACA may lose it. He noted that the number of patients without insurance at the public hospital where he works dropped from about 16–18% before the ACA to about 4% after. Those most vulnerable to losing coverage are patients, particularly minority patients, who also have the greatest risk of advanced chronic kidney disease (CKD), he noted.

"For CKD patients, it could destabilize their insurance and reduce their access to care," he said.

Both President Trump and House Speaker Paul Ryan (R-WI) have proposed changing Medicaid into a block grant program, which they say would give states more flexibility in how they administer the program. These changes could mean that coverage under Medicaid would vary by state.

"I'm concerned about Medicaid block grants to states, which I think will allow more latitude and perhaps unintentionally block people from access to insurance products," Sedor said.

The effect of this change on health care providers would likely depend on which state they practice in, Silberzweig noted. For example, the Rogosin Institute is based in New York State, which has been generous in providing access and funding for the state's Medicaid program.

"It would have less of an impact [in states like New York], than in states that have not historically been as generous," he said.

Innovation projects

The United States has launched several efforts in the past 8 years to shift away from a fee-for-service payment model for physicians to value-based payments. The future of the Center for Medicare & Medicaid Innovation (CMMI), which administers many of these models, may hang in the balance as Republicans reshape health reform.

The 2015 MACRA legislation, which established a new system for Medicare payments for doctors that emphasizes value-based care, was passed by huge bipartisan majorities in both houses of Congress, noted Robert Doherty, senior vice president of policy and government affairs at the American College of Physicians, during a session on alternative payment models at Kidney Week 2016 in November. The MACRA legislation, which goes into effect this year, is unlikely to be changed under the new administration, he noted.

But the CMMI, which was created under the ACA and also has a role in MACRA, could be in jeopardy. The CMMI was created to test and fund various innovative payment and quality improvement programs, including the Comprehensive ESRD Care Model and the Medicare Shared Savings Program.

"Here's the one interface with ACA that has me concerned," Doherty said. "If Republicans deliver on repealing all of the [ACA], the innovation center would go away. Where would the funding come from for all the projects being supported by the [CMMI]?"

The CMMI has been unpopular with Republicans, noted Sedor. For example, more than 150 Republican congressmen and women sent a letter to Centers for Medicare & Medicaid Services administrators in September 2016 arguing that the CMMI had overstepped its authority in creating mandatory payment demonstration projects (http://bit.ly/2d1CDRY). Among those signing the letter was Sen. Tom Price, MD, (R-GA), and President Trump's nominee to head the Department of Health and Human Services.

It might be possible to create other mechanisms besides the CMMI to take over MACRA-related roles, Sedor said. "We're going to have to wait and see how things evolve when they take over," he said.

Organizations, like the Rogosin Institute, that are participating in the the Comprehensive ESRD Care Models and have invested heavily in infrastructure and staff for the projects are concerned about what will happen to their projects if CMMI disappears.

"It would be very difficult for us if they completely pulled funding for existing projects," Silberzweig said. "I think it would be fairer to continue funding existing projects at least for the demonstration period that was part of the original proposals and not fund new projects."

"My view is that we all need to proceed cautiously at this point until we get into [the new year] and the new administration steps in and does whatever they are going to do," Silberzweig said.

Sedor urged the administration and Congress to carefully consider the impact of any changes they make on people who are currently covered under the ACA.

"I'm a fan of the ACA," he said. "It certainly has issues that need to be addressed. But it was a game changer in terms of providing access to millions of people who were uninsured."

What Do Fellows Want? What Does Nephrology Need?

By Joseph Mattana, MD

After several years of declining interest, the future of nephrology as a career choice continues to be uncertain. Preliminary results from the Nephrology Match AY 2017 revealed a continuing trend toward unfilled nephrology tracks, with almost no change from AY 2016 (95 vs. 93 filled tracks). Programs may face the difficult choice of trying to recruit post-match or perhaps reducing program size and recruiting either more attending nephrologists or physician extenders including physician assistants or nurse practitioners.

Last year's match rate for nephrology was the lowest for all medicine fellowships. A particularly noteworthy trend has been the progressive decline in the number of international medical graduates (IMGs) matching in nephrology, with only 100 for the current academic year, down from 192 as recently as 2011.

As has been well described elsewhere, careers in nephrology have been viewed less favorably in recent years for a variety of reasons, including perceived lower compensation compared to many other fields along with a workload and quality of life felt to be inferior compared to other specialties. There is also concern regarding the ability to find nephrology jobs, with a large proportion of fellows describing difficulty finding positions in nephrology after graduation, as described in the 2015 Survey of Nephrology Fellows.

Need for innovations

Other factors may be playing a role as well. Dialysis and transplantation represent extraordinary therapeutic milestones that transformed end stage renal disease care, and these modalities have continued to improve. However, many fellows and trainees who are considering careers in nephrology are looking for new therapies comparable to what they see taking place in other fields. Trainees describe seeing many recent advances in cardiology, rheumatology, hematology/oncology, and endocrinology with new therapies regularly introduced. In contrast, for a number of renal conditions such as diabetic nephropathy, many note that there have been no major new therapies introduced in the past several decades with a string of disappointing clinical trials.

There are potent competing forces as well. Careers in hospital medicine appear to be a frequent alternative chosen by trainees considering nephrology careers. Better compensation, controlled schedules, and perceived better quality of life draw a number of residents away from nephrology. Whether such choices typically lead to long-term career satisfaction remains to be determined.

There have been some favorable trends whose impact will require observation over the next year. While the high percentage of fellows reporting difficulty in finding a satisfactory job as noted above is of great concern, this percent-

Continued on page 14

What do Fellows Want?

Continued from page 13

age has recently fallen, mostly for US medical graduates, but to some extent for IMGs as well. If this trend continues, we might see a positive impact on the perception of nephrology by residents considering it as a career and hopefully greater career choice satisfaction for nephrology fellows.

Nephrologists' role in emerging health care

At the same time that changes in the nephrology workforce and in what fellows want are taking place, several variables are affecting the emerging needs of nephrology. There has been a decline in the incidence of ESRD, likely in part due to more aggressive treatment to slow progression of CKD. Nephrologists will need to continue to be a part of this effort if this trend is to continue. Despite a decrease in incidence, the prevalence of ESRD has increased, due to factors such as the growth of the population, with a large percentage having diabetes mellitus and hypertension, and improved dialysis care leading to a reduction in mortality. Nephrologists will obviously be essential to their care, even as the role of physician assistants and nurse practitioners continues to evolve.

Kidney transplantation has seen the introduction of new agents such as belatacept that require additional expertise on the part of nephrologists. Hence a larger number of nephrologists who are highly competent and comfortable in the use of such therapies may be needed. The nephrology workforce, as for many other physician specialties, tends to be unevenly distributed across the country, with some areas having high concentrations of nephrologists and others with a severe shortage and large obstacles to recruitment. Challenges with recruitment to certain areas could potentially be addressed through telemedicine, for example in areas with large distances between dialysis units.

A further area of uncertainty that will affect the needs of nephrology will be the impact of emerging models of health care including the roles of physician extenders. For example, as described in the US Adult Nephrology Workforce 2016 Report, the ESRD Seamless Care Organization (ESCO) will be one such model whose potential impact cannot be determined at this time in terms of the job market for nephrologists. Whether through an ESCO or other model, increased use of physician assistants and nurse practitioners is a phenomenon whose impact on future career opportunities for nephrologists merits close watching.

Nephrology has made enormous advances but is in need of much more progress to ensure the ability to draw fellows who will pursue careers in clinical practice as well as those with potential for careers as nephrology researchers and educators. The excitement and vast potential of nephrology research, the deep personal rewards that come from caring for patients with renal disease, and the satisfaction derived from mastery of the subject matter of nephrology while maintaining a strong command of general internal medicine all need to be communicated to students and residents. Novel elective models and other interventions to expose students and residents to a broader spectrum of nephrology have been proposed and are being utilized at various institutions, with impacts that deserve further study. It is hoped that over the coming year we will start to see some reversal in the recent trend away from pursuing careers in nephrology and gain further insights in how to facilitate this.

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The Nephrology Care Team: Whose Responsibility is it to Educate?

By Amy Williams, MD

Leaving ASN Kidney Week 2016, I was excited to integrate new knowledge and thoughts into processes to improve the care and outcomes of patients with advanced CKD. Realizing that outcomes for these patients depend on early identification and appropriate management throughout their disease trajectory with attention to transitions across settings of care, and during disease progression or additions of co-morbidities, begs the question: Whose responsibility is it to bring up-to-date knowledge to the community primary care practitioners, home health agencies, other subspecialists, and anyone else who participates in the care of those with CKD 4+?

A critical first step in answering this question is defining who is on the extended care team and what role each team member plays. Certainly the team's anchor is the patient, but the captain or general manager must be the one with the most knowledge related to managing the patient population. For CKD and particularly CKD 4+, it is the nephrologist.

Patients have told us that to gain maximum usability of information, they want timely, transparent, open, and honest conversations that contain information with a tight feedback loop translated on their level and relevant to their current disease state. They also ask that all members of their care team have and share the same information to avoid confusion. Whose responsibility is it to manage the information? It is the nephrologist's.

With crammed office schedules and many competing responsibilities, the nephrologist does not have the luxury of spending the time needed with each patient to adequately educate them on their disease and treatment options, including conservative care. Reliable processes are needed to monitor disease progression, co-morbidities, and treatment effectiveness. Without effective and efficient processes, patient safety and outcomes are at risk. Health care delivery systems with multidisciplinary teams educated about the target population and disease cluster, captained by the content expert provider, can mitigate these risks.

Patients want a continuous connection to their medical care team, but only want a face-to-face meeting when necessary. Education theory tells us that the most effective learning method is iterative with repeated discussions and teach-back. A 15-minute office visit with the nephrologist will not accomplish this goal. In fact, the time the nephrologist has with the patient is critically valuable—and should focus on discussions and complex decisions that only the nephrologist is trained to do.

Care teams should be designed to easily share knowledge across settings, accomplishing this through web-based care algorithms and links to educational materials.

Also, it is not patient-centric to interrupt patients' lives for an office visit if the assessment and care decision can be made virtually through synchronous, live, two-way video interactions between the patient and care team member—RN, advanced practice provider (APP), dietician, social worker, pharmacist, and if needed, the nephrologist, using audiovisual telecommunication technology. Review of health records or lab data via asynchronous transmission to the nephrologist—possibly reviewed and triaged by a trained RN or APP with knowledge and algorithms to determine whether the patient should be seen in the office or not—can be effective and efficient. Managing ESRD patients either at home or in-center is also best when team-based. We are accustomed to employing a team-based model in dialysis units, depending on the social worker and dietician to fill in our skill and knowledge gaps, or nurses to lead just-in-time educational sessions with patients. These models should be expanded to pre-ESRD care models.

It is important to include other providers who care for the advanced CKD patient on the team. Shared care plans, knowledge of best practices and electronic health records, as well as establishing easy referrals using face-to-face office visits or virtual evaluations are important steps to smooth care and disease transitions resulting in improved outcomes for this complex patient population.

As the CKD population increases and decisions for patients with complex chronic disease become more complicated, it is imperative that nephrologists stay in the captain or general management role, leading the care team by sharing their knowledge and expertise and giving timely input. Success depends on staying connected to patients in a way that supports them when they need support. Care teams should be designed to easily share knowledge across settings, accomplishing this through web-based care algorithms and links to educational materials. The key is to have the resources available to the providers and care team members when they need it—at the bedside or in the office.

In summary, to accomplish population management in the CKD 4+ complex chronic disease population, nephrologists must develop expanded care teams that include flexible partnerships with other providers and the community. Their responsibility as general manager or captain includes coordinating consistent integrated flow of information, and developing an expanded CKD/ESRD team with standardization of care and of care team members' roles—including the patient. Accomplishing this should lead to the goal of improved outcomes through effective management of kidney disease and the co-morbid conditions common in patients with advanced kidney disease.

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