State of Kidney Care 2017

Kidney Care Provider CMOs

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Last year the Kidney Care Provider Chief Medical Officers (CMOs) offered a perspective on the State of Kidney Care in 2016. Some issues have remained the same in 2017, but the fast pace of change in many areas warranted an update. Health care in the US is undergoing transformation as Medicare moves from volume-based fee-for-service to value-based payment systems. In the next two years, it is possible that more than 50% of Medicare payments could be made in Advanced Alternative Payment Models (APMs) regardless of what happens as a result of efforts to repeal and replace the Affordable Care Act. There currently are 561 Accountable Care Organizations (ACOs) (120 of these are risk bearing) with a total of 12.3 million patients receiving care in an ACO. In 2017, 85 new ACOs were started.

Challenges

1. Transformation of the health care system and the practice of nephrology:
   The systemwide transformation of US and global health care means providers are increasingly accountable for clinical outcomes as well as the total costs of care. Nephrologists need to be leaders in this transformation, which will impact them in all of the realms in which they practice: dialysis facilities, offices, and hospitals. While individual nephrologists and practices will be differentially affected by this transformation, all will be affected to some extent and need to be prepared to thrive in the new world of care delivery and reimbursement/payment systems.

2. Where nephrologists and kidney care providers fit in the new health care system:
   Nephrologists and kidney care providers will be at the forefront of the new health care system because of the disproportionate cost of advanced CKD and ESRD patients. Innovative solutions for improving care and controlling costs are needed. Going forward, nephrologists and dialysis providers will need to work together to ensure that these solutions are identified, tested, and implemented. Nephrologists will have more options regarding their clinical work environment, with an increasing number likely to find salaried positions with health systems, integrated health care organizations, physician groups, hospitals, or dialysis providers. Career advancement programs need to be broadened to inform nephrologists of the benefits and pitfalls of these options.

3. The critical role of health information technology:
   Integral to the success of integrated care is the ability to seamlessly share patient information through electronic health records (EHRs). Nephrologists often use multiple EHRs in the different settings in which they practice and are perhaps more aware of the need for seamless integration of these information systems than other physicians. Nephrologists need to lead the design of more usable systems and algorithms to enhance sharing of information in real-time fashion, an effort that should include interoperability, a common lexicon, and agreed-upon metrics and business rules so meaningful use of the massive amount of available data is possible.

4. Influence of regulatory oversight and public data on patient care:
   There is a need for increasing rigor in the development and selection of quality metrics to ensure they have an impact on the quality of patient care. Oversight of quality in the payment system through the Quality Improvement Program has been one of the primary approaches by the Centers for Medicare & Medicaid Services (CMS), but further refinement of QIP measures and methods used to calculate them needs to be informed by evidence, sound methodology, and in the future include patient-reported outcomes. By engaging in the research and development of such accountability systems, nephrologists can lead the development of important quality measures rather than waiting for CMS to dictate them. Nephrologists may act as individuals and through professional organizations such as ASN and the Renal Physicians Association (RPA), as well as through national coalitions such as Kidney Care Partners, Kidney Care Coalition, and the National Renal Administrators Association (NRAA). Nephrologists must be active advocates for patients and for the discipline of nephrology. Accountability should be an area developed and structured through the discipline, not by regulators.

5. The nephrology workforce:
   Care of patients with kidney diseases and kidney failure will be dependent on teams including nurses (RN and NPs), social workers, care coordinators, patient care navigators, health coaches, patient care clinicians, technical specialists (e.g., podiatrists, cardiologists, endocrinologists, vascular surgeons), insurance/benefits experts, and others who focus on social determinants of health, such as housing, nutrition, transportation, and employment. Another aspect of integrated team-based care is improved palliative care for symptom management during life and care at the end of life. The nephrologist needs to be the leader and coordinator of this team.

The lack of interest in nephrology careers among medical students and residents will make it difficult to reach sufficient numbers and quality of nephrologists to meet needs spanning clinical care and administrative functions. Attracting more trainees to nephrology will require changing the approach to teaching the discipline. Too often the emphasis on basic physiology does not “connect the dots” with the implications of organ dysfunction leading to the many manifestations of CKD and ESRD that patients exhibit and that make the specialty so fascinating, yet complex. Students and residents must be exposed to outpatient CKD management and to care of dialysis and transplant patients outside the inpatient setting. In this way the successful and rewarding outcomes of kidney patient care are better conveyed. Articulating the leading role of nephrology in defining and implementing value-based care, palliative care, and driving public policy should also attract talented trainees who are looking for new career paths.

For kidney care, 24 new ESRD Seamless Care Organizations (ESCOs) started in 2017, bringing the total to 37. Currently, 46,000 patients receive care in an ESCO and 1291 physicians are owners in ESCOs. All but three of these ESCOs are Advanced APMs, allowing for the possibility of nephrologists owners to receive a 5% bonus payment from Medicare in 2019. Should the Center for Medicare and Medicaid Innovation (CMMI) choose to extend the ESCO program after 2018, as many as 15% of all Medicare ESRD patients could be enrolled in an ESCO over the next 5 years.

In addition, we see increasing appearance of Medicare Advantage Special Needs Plans (cSNPs) for ESRD patients and the attempt to create additional opportunities to deliver value-based care through the PATIENTS ACT, an alternative value-based care model to ESCOs and cSNPs.

This rapid pace of innovation in kidney care creates an incredible opportunity for the discipline of nephrology and the nephrologist to help shape care delivery and payment for kidney patients as well as other complex chronically ill populations, creating significant improvements in patient outcomes, while responsibly stewarding resources.

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Integrated care and the ideal role of the nephrologist: The nephrologist’s role varies depending on the site of focus of care. A nephrologist assigned to a dialysis facility may serve as the critical care physician, the acute care specialist, and the chronic care specialist. The nephrologist for the chronic care population is tasked with the care of patients with end-stage renal disease (ESRD), while the acute care nephrologist is tasked with the care of patients with acute kidney injury (AKI). The critical care nephrologist is tasked with the care of patients who are critically ill due to kidney failure. Each role requires different skills and abilities, and the nephrologist must be prepared to take on all of these roles in order to provide the best possible care for their patients.

Opportunities

Improving care for patients with acute kidney injury: Kidney health providers are now treating a larger number of patients with AKI in outpatient facilities. It is essential that we recognize that a patient with AKI has different needs than a patient with ESRD. In a collaborative partnership, nephrologists and providers need to work on a better model of care for patients with AKI, with the primary goal of recovering kidney function where possible or preparing for chronic renal replacement therapy (RRT) when necessary. Sharing of best practices will inform the development of an improved model of care for AKI patients. ASN can play a critical role in sharing what we are learning to a broader audience.

Improving access to home dialysis: Most nephrologists and clinicians would choose home dialysis for themselves, yet few patients on dialysis are able to benefit from dialysis at home. A patient dialyzing at home has more autonomy, is more likely to continue to work, and has more satisfaction in their kidney care. Nephrologists and other providers should work together to identify opportunities to make it more likely that patients can dialyze at home. They should reevaluate curriculum structure and requirements for training and competence in home dialysis because many training programs do not have a sufficiently large home dialysis program to adequately train fellows. In addition, recent events have illustrated, availability of adequate supplies to carry out home dialysis and lack of innovation in delivery systems has hampered the further growth of these modalities.

Increasing access to kidney transplant: Most agree that transplant is the optimal therapy for patients with kidney failure who are medically suitable. Yet few patients benefit from transplant, with only 10% of patients with kidney failure receive a preemptive transplant as treatment; the remaining 97.4% start dialysis. We need to emphasize transplantation as a care modality for patients with ESRD and ensure nephrologists view it this way.

Nephrologists, organ procurement organizations, transplant programs, and kidney health providers should work together to approach the problem in innovative ways. The nephrologist must develop a comprehensive approach, including education and training, and ensure nephrologists are trained and prepared to perform transplantation. This need also extends to patients’ conservative therapy. This need also extends to patients’ ability to choose integrated care plans, Medicare Advantage plans, or maintenance of private insurance (including the use of charitable premium assistance where appropriate) when it is in their best interest.

Promoting innovation in CKD and ESRD care: A concerted focus on continuous innovation in the care of patients with kidney disease is needed. There should be strong support for the existing vehicles for developing innovative approaches to improving outcomes, but also efforts to advance basic science understanding of CKD and ESRD and pragmatic solutions to care delivery and financing problems. Examples of existing programs are the Kidney Health Initiative, CMMI special projects, Nephrologists Transforming Dialysis Patient Safety, and the Center of Dialysis Innovation. More such programs are needed.

Additional specific areas of focus given a high priority by the CMOs include the following:

- Revisiting the definition of “adequate” dialysis.
- Defining evidence-based criteria for alternative dialysis regimes.
- Optimizing the use of self-care modalities.
- Defining, utilizing, and harmonizing meaningful quality metrics that reflect care that is relevant and important to patients.

Achieving the goals stated here will require a close working relationship among kidney health providers, nephrologists, and nephrology fellowship training programs. By establishing a closer partnership, kidney care provider CMOs and ASN can build toward a stronger future for providers, nephrologists, and patients. An important aspect of this link is the establishment of a committee of representatives of both groups with the aim of enhancing career development for early career nephrologists and nephrology trainees. Such a program should aim to enhance skills in the clinical management of patients with advanced CKD, foster a better understanding of the financial and legal impacts of the changing health care system, and improve opportunities for research in quality metrics and improvement.

We are currently at a time of rapidly accelerating change in American health care, and the care of kidney patients is at the forefront of this ongoing transformation. The movement to value-based care offers challenges to our discipline but also offers a tremendous opportunity to improve outcomes. Value-based care is the foundation of quality care for patients with kidney diseases. The CMOs are interested in strengthening our collaboration with ASN. Possible opportunities to increase collaboration include:

- Regular meetings of ASN leadership and kidney care providers.
- Definition of a common set of issues to be addressed jointly.
- Exploration of how the kidney care organizations can assist ASN in reaching out to potential nephrology trainees.
- Exploration of how the kidney care organizations can assist ASN in ensuring that trainees have access to the necessary training in CKD and ESRD patient care that will likely be the focus of practice for many.
- Serving on the ASN Career Advancement Committee.
- Contributing to the planning process for ASN Kidney Week.
- Partnering to work with CWC, including the efforts of the Healthcare Infection Control Practices Advisory Committee.