

Can Future Value-Based Care Models in Nephrology Promote Kidney Transplantation?



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Value-based care (VBC) has taken center stage in nephrology with goals of providing high quality coordinated care for patients with advanced chronic kidney disease (CKD), performance assessment for providers, and lower costs for payers. A lack of emphasis on kidney transplantation was a concern for early VBC nephrology programs. For example, the Comprehensive End-Stage Renal Disease Care model had no quality measure or incentive for transplantation.¹ Recent programs, arising from the 2019 Advancing Americans Kidney Health initiative,² have focused on improving organ accessibility and kidney transplantation. The mandatory End-Stage Renal Disease Treatment Choices and the voluntary Kidney Care Choices include incentives or penalties for kidney transplantation.³

The Centers for Medicare and Medicaid Services has furthermore introduced changes to Organ Procurement Organizations such as annual reviews of performance, publicly reported rankings, and changes in the methodology of measurement to support transplantation.³ The End-Stage Renal Disease Quality Incentive Program, a mainstay for dialysis clinics since 2011, only added a transplantation reporting measure in Payment Year 2022.⁴

Despite these well-intentioned recent interventions, there is growing concern that the incentives (and penalties) for kidney transplantation in the VBC programs may be insufficient. As early data from End-Stage Renal Disease Treatment Choices suggest small but statistically insignificant changes in transplantation rates,⁵ momentum is building to make foundational changes to the next iteration of VBC programs. Payers, such as Centers for Medicare and Medicaid Services, the largest single payer source for dialysis care and transplantation, are in a unique position to incentivize providers to shift treatment for

kidney failure away from dialysis and toward transplantation. Indeed, policymakers, payers, and providers must collectively reimagine the approach necessary to make transplantation the first option for patients.⁶

In this issue of the journal, Hippen and colleagues propose a fundamentally new payer model: A Transplant-Inclusive VBC (TIVBC) payment model.⁷ The authors describe innovative approaches to preferentially guide the medical trajectory of patients with advanced CKD toward transplantation as they navigate the complex medical landscape of transition from one kidney replacement therapy modality to another (and back).

First, the authors propose population screening that elevates transplant advanced care plans and care coordination as a quality gateway measure. This approach draws upon the experience of using gateway measures in the Kidney Care Choices model such as the Patient Activation Measure and depression remission measured at periodic intervals. Second, the authors describe a unique Referral, Evaluation, and Waitlisting triage system that focuses on listing patients who have the highest chances of being transplanted within 18 months. The authors detail the potential benefits of such an approach (including efficiency, cost savings, and transparency in the waitlist). Third, from the financial perspective, they propose an episode-of-care (EOC) model, which differs from the total cost of care model seen in previous nephrology VBC models. The authors argue that an EOC—defined as a health event needing testing, diagnosis, care, and follow-up from initial presentation to resolution—would align itself best to the

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multiple phases of care for patients with advanced kidney disease, such as receipt of transplants, initiating or returning to dialysis. Within each EOC, they propose either a 30-day primary hospitalization cost, or a 180-day (extended out from) primary hospitalization cost, and a EOC to include graft survival or outcomes for 5 years, longer than the 3 years incentivized by the Comprehensive Kidney Care Contracting option in the Kidney Care Choices model.

At its core, the TIVBC model is a logical advancement in VBC programs. The goals are measured with a focus on improving access, a mindful approach to equity, a major change to the evaluation and listing process, a desire to measure graft longevity for an extended time, and a focus on transition to end-stage kidney disease when the patient with a kidney transplant develops CKD. For example, the gateway measures in the pretransplant phase would incentivize close follow-up and listing of patients, hopefully leading to more organized care coordination pathways. Similarly, the long-term follow-up of graft longevity to 5 years, and the focus on transition to end-stage kidney disease when the transplant fails, may promote a holistic and long-term approach for the care of these patients. This approach also incentivizes transplant centers to be engaged in the care of these patients longitudinally, rather than a shorter time frame (especially as the cost-benefit ratio from a transplant vs. dialysis becomes more evident as more time elapses with a functioning allograft). The authors also suggest ways to consider risk adjustment and financial models that allow increasing access to these organs, and the gift of transplant to higher risk patients without penalizing the transplant program. The EOC is designed to allow delineating costs

that are truly attributable to a transplant program; excluding costs centers such as those involved in organ procurement and logistics would ensure that a TIVBC does not negatively impact innovation and growth in the field of transplantation.

As with any new proposal, the TIVBC model raises several concerns. At first glance, the medical complexity of patients with advanced CKD appears to make them an ideal population for an EOC program. However, data on the effectiveness of EOC are currently insufficient to predict success of the proposed model. Improvement in cost and quality have only been demonstrated among patients with narrow or discrete conditions such as myocardial infarction or joint replacement.⁸ Furthermore, the definition of quality in EOC models has traditionally been reductions in 30-day readmission. In the kidney transplant space, one of the main quality metrics would have a fundamentally different definition—increasing the absolute number of transplants.

It is also unclear how TIVBC model would optimize the complex administrative relationship of transplant centers, the United Network for Organ Sharing, the Organ Procurement and Transplantation Network, and Organ Procurement Organizations. The financial implications of TIVBC may be immense: decreasing pretransplant evaluation-up revenue for transplant centers because of streamlined referrals from the Referral, Evaluation, and Waitlisting triage model; lack of clear administrative data to delineate transplant costs from others; and the reluctance of transplant centers to assume shared risk in this population with a high burden of disease, and hence high cost of care, especially in the absence of well validated risk adjustment.

Large dialysis organizations, and more recently, for-profit CKD management companies have increased participation in VBC programs such as the Comprehensive End-Stage Renal Disease Care and Kidney Care Choices. Administratively and structurally capable, these companies would have expanded influence, thereby raising concerns about how these organizations may affect the relationship between nephrology providers and patients, the independence of transplant centers, the United Network for Organ Sharing, and other entities as well as the overall landscape of nephrology care space.

Finally, the Referral, Evaluation, and Waitlisting triage system in the TIVBC may adversely affect transplant disparities. The Referral, Evaluation, and Waitlisting triage system, fast-tracking transplant candidates, may lead to “cherry picking” the best-resourced candidates and “lemon-dropping” candidates with a high burden of social determinants of health. Although the authors recommend guardrails, further details are required; a recent paper may provide additional insights on how to mitigate disparities.⁹

In conclusion, transplantation is the preferred form of kidney replacement therapy for all stakeholders—patients, providers, and payers. The proposed plan is both a logical progression of VBC plans and a radical redesign with a goal of being intentional in our strategy to increase kidney transplants, reduce redundancies and provide meaningful performance-based incentives to the transplant centers.

DISCLOSURE

All the authors declared no competing interests.

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