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## **Bandages will not fix a fractured system of chronic kidney disease care: Why the Dialysis PATIENTS Demonstration Act cannot be supported by the transplant community**

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The Dialysis PATIENTS Demonstration Act (DPDA) (H.R 4143/S.2065) is proposed to improve the value of care for dialysis patients. In this issue of AJT,(1) Becker and Nissensen (who work for Da Vita), write to reassure the transplant community that transplantation remains a priority under the DPDA. They express “hope” that the DPDA will be neutral or have little impact on transplantation, while omitting reference to the competitive advantage Da Vita would enjoy under the DPDA. Large dialysis providers such as Da Vita, could more

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easily assume the risk of all of dialysis patient costs (over \$80,000 per patient per year), as envisioned in the DPDA, compared to smaller and non-profit dialysis providers.

In this editorial, we challenge the premise that the DPDA will increase the value of care provided to chronic kidney disease (CKD) patients and propose the need for alternative, more comprehensive patient centered models that will align stakeholder interests rather than perpetuate the current fractured system of CKD care in the U.S. in which transplantation is frequently not considered at all or an afterthought.(2)

Value in healthcare is defined by the quality of care provided relative to the cost for providing care. The poor quality (measured by inferior patient survival) and high cost (consumption of 90% of the ESRD Medicare budget) of dialysis in the U.S. relative to other developed countries has long been recognized.(3) As reviewed by Becker and Nissensen, recent programs to improve dialysis outcomes have included efforts to improve the integration of dialysis care.(4, 5) The DPDA is merely another example of these efforts which by focusing solely on dialysis are too narrow in scope and fail to recognize that the problems with dialysis are only part of a bigger problem with the organization of CKD care in the U.S.

Although there may be modest gains recognized from improving the integration of care among dialysis treated patients, it is obvious that the focus of any integrated CKD care model must be to *minimize* the number of patients who require chronic dialysis treatment (by investing in strategies to prevent and slow the progression of CKD), and to *maximize* the use of transplantation (which provides greater survival, quality of life and cost savings compared to dialysis) among patients who develop ESRD.(6)

Under the proposed DPDA, care providers (the nephrology community) are not incentivized or empowered to optimize the road to transplantation for their patients and there is a covert financial disincentive to provide transplantation as a treatment. The success of this five-year demonstration project would primarily be assessed by improvements in dialysis care processes and related cost savings. The inclusion of a few minimal standards for transplantation, is unlikely to mitigate the strong financial incentive to maintain patients on dialysis. It is foreseeable the patients enrolled and maintained in the DPDA will be phenotypically at “low risk” for high health care utilization,(7, 8) and will contribute significantly to the denominator of the cost per member ratio that drives provider profit in the model proposed by the DPDA. Since pre-ESRD and post-transplant patients are excluded, there is no accountability or potential for cost savings for improving the care of these patients (i.e. through pre-emptive transplantation or improved transplant survival), and there is a passive disincentive to promote transplantation. Recent amendments to the DPDA include the requirement of input from a transplant surgeon and the establishment of a minimum threshold for the volume of individual patients to be listed for transplant, but they do not include explicit provisions to increase living and deceased donor transplantation or to improve post-transplant outcomes. Further, they are insincere and insufficient to assuage the transplant community’s concerns about the DPDA.

A truly integrated CKD care model should be centered around the patient and not organized by treatment modality (i.e. pre-end stage, dialysis, transplantation).(9) Providers would be contracted to manage *all* aspects of CKD in the entire population. Accordingly, providers would focus on treatments that provided the most value (best outcomes for least cost) including preventing CKD (e.g. by screening high risk groups), slowing progression of disease (e.g. through multi-disciplinary CKD clinics), and maximizing the use of transplantation among patients who progress to ESRD (e.g. by investing in living and deceased organ donation, re-designing post-transplant care models, and funding the cost of

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immunosuppressant drugs to improve long-term transplant survival and decrease the need for repeat transplantation).

Our assessment of the value of transplant care must evolve to include the broader perspective of patients on dialysis, and the long-term outcomes of transplant recipients (including those who return to dialysis after transplant failure), and we must advocate for systematic changes that will improve the outcomes of these patients who are currently out of sight and out of mind. Expanding our reach to these patients is unrealistic without the partnership of the general nephrology community and dialysis providers. Sadly, the DPDA was conceived without any input from the transplant community. This is deflating as Dr. Becker has lamented past events in which the needs of transplant patients were pitted against those of dialysis patients leading to failure of legislative efforts to secure lifelong coverage of immunosuppressant drugs for kidney transplant recipients.<sup>(10)</sup> Given the reality of finite resources, dialysis providers must consider the impact of their proposals in the context of the overall value to the system. While we may differ in opinion with Becker and Nissensen as to whether the DPDA will exacerbate disparities in access to transplantation, it is apparent that bill will not increase transplantation. We are confident that the inclusion of the transplant community in future efforts to improve the care of CKD patients would avoid similar policy blind-spots.

The formidable task of redesigning the organization of CKD care does not preclude the transplant community from moving forward with strategies to improve access to transplantation. These include removal of financial disincentives to living kidney donation, investment in novel strategies to enable patients to identify a living donor, increasing the utilization of high donor profile index kidneys and kidneys at increased risk for infectious disease transmission as defined by the Public Health Service, revision of regulatory and

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reimbursement policies that directly or indirectly lead to non-use of higher risk organs and non-acceptance of higher risk patients who will benefit from transplantation, and advancement of new post-transplant care models to improve long-term transplant survival.

In summary, by focusing solely on dialysis the DPDA is too narrow in scope to have significant impact on the value of CKD care, will exacerbate disparities in access to transplantation and has the potential to decrease the use of transplantation as a treatment for patients with ESRD. The development of the DPDA without input from the transplant community is symptomatic of a larger problem with the modality-based organization of CKD care in which the interests of stakeholders are not aligned to improve the value of patient care across the entire spectrum of CKD. The inclusion of minimal requirements for transplant and improved transplant education in the DPDA are woefully inadequate measures. System redesign focused on investment in therapies that provide the most value including disease prevention, and transplantation is necessary but will be slow to achieve and will require the collaboration and leadership of all stakeholders. In the meantime, the transplant community should move forward with tangible solutions to improve patient access to transplantation.

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