Ensuring the Equitable Advancement of American Kidney Health—the Need to Account for Socioeconomic Disparities in the ESRD Treatment Choices Model

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INTRODUCTION

The finalized ESRD Treatment Choices (ETC) payment model was announced by the Centers for Medicare & Medicaid Services (CMS) on September 18, 2020.1 Recognizing the underutilization of home dialysis and kidney transplantation, CMS introduced the ETC model as part of the Advancing American Kidney Health (AAKH) initiative—a broadsweeping initiative to transform care for patients with kidney failure.1 In keeping with two central AAKH goals, the ETC model will adjust payments to incentivize home dialysis and transplantation. Given the large-scale, mandatory nature of the model, it is critical that CMS continues to refine the model on the basis of public feedback from participants, patients, and organizations. Substantial concern remains that the model does not incorporate risk adjustment—particularly for social determinants of health (SDOHs), such as housing instability, socioeconomic status, and access to care.2 Although strategies to address health care disparities that leverage the broader AAKH initiative have been discussed previously, this perspective serves to summarize key aspects of the ETC model (a specific payment model within AAKH), spotlight concerns regarding the effect of the model on health care disparities, and suggest strategies to promote health equity.

THE ETC MODEL—A HIGH-LEVEL OVERVIEW

The ETC model is a payment model that will adjust Medicare dialysis payments across a random selection of 30% of Hospital Referral Regions between January 2021 and June 2027.1 Participants (i.e., dialysis facilities and nephrology practices) will receive two types of payment adjustments. First, the Home Dialysis Payment Adjustment (HDPA) will increase payments for home dialysis claims during the first 3 years of the model. Second, the Performance Payment Adjustment (PPA) will increase or decrease payments for all dialysis claims made by participants starting in July 2022. The magnitude of PPA is determined by a participant’s rate of home dialysis (peritoneal dialysis, home hemodialysis, and self-care dialysis) and transplantation (living donor transplantation and wait-listed for transplantation). By comparing these rates with nonparticipants and historical benchmarks from the same participants, CMS will assign a Modality Performance Score. On the basis of this score, participants receive increasing payment adjustments, from a range of −5% to +4% in July 2022 to a range of −10% to +8% in June 2027.1 Overall, PPA encourages home dialysis, transplant wait listing, and living donation through payments that incentivize care delivery reform.

THE IMPORTANCE OF ACCOUNTING FOR SOCIOECONOMIC FACTORS IN THE ETC MODEL

The ETC model aligns care with incentives to promote patient choice, improve quality of life, and lower costs.1 Although conceptually appealing, early value-based care models have disproportionately and inadvertently penalized health systems caring for socially disadvantaged patients.3,4 The ETC model risks doing the same as it does not account for socioeconomic factors that (1) are associated with decreased use of home dialysis and transplant and (2) may require greater investments in care delivery. These factors include (and are not limited to) housing instability, income, education, occupation, insurance coverage, and access to care.5,6

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The National Quality Forum recommends risk adjustment for sociodemographic factors in a value-based care model, provided there is empirical evidence of a conceptual relationship between the factor and quality metric measured. Patients with housing instability represent a high-risk, understudied population suffering from insufficient housing, homelessness, or financial insecurity coupled with high housing costs. Housing instability virtually precludes the use of home dialysis, limiting patient choice. Further, limited data suggest higher rates of worsening albuminuria and progression of CKD, in-center dialysis, missed dialysis treatments, emergency-only dialysis, hospitalizations, and health care costs. Without appropriate risk adjustment, participants who care for patients with housing instability are at risk for financial penalties under PPA, leading to disincentives to provide equitable care for disadvantaged patient populations. Similarly, social determinants influence the likelihood of transplant wait listing and living donation; without appropriate adjustment, ETC participants are disincentivized from accepting patients with perceived barriers to transplantation. These disincentives could worsen disparities, similar to other value-based care models.

**STRATEGIES TO PROMOTE EQUITY IN THE ETC MODEL**

To advance the care of all patients with kidney disease, CMS should consider multiple strategies to improve health equity within the ETC model. We describe three strategies below: improved documentation of SDOH, risk adjustment for home dialysis, and coordinated care for disadvantaged patients.

First, to address SDOH, we need better data. Currently, SDOH can be documented using International Classification of Diseases, tenth revision Z55–Z65 codes (e.g., Z59.0 for homelessness). Unfortunately, in 2017, only 5% of patients covered by Medicare Part B had any documented Z55–Z65 code. Given this lack of data, CMS chose not to account for patients with housing instability in the ETC model. To improve documentation, some authors have proposed mandating reporting of socioeconomic factors, such as housing instability and employment, in the CMS-2728 and CMS-2744 forms submitted by dialysis facilities. Another option is to incentivize Z-code documentation; if risk adjustment for SDOH is tied to Z codes, the ETC model could improve SDOH documentation for patients with kidney failure, allowing targeted clinical care and research to improve equity.

Second, alongside better SDOH data, CMS should prioritize payment adjustments for SDOH. Although CMS considered excluding patients with housing instability from the model, we caution against this. Excluding disadvantaged patients from the ETC model risks de-prioritizing the same patients who require greater investments in care; this could cause discrimination or “lemon-dropping.” Rather, CMS should incorporate payment adjustments on the basis of SDOH to HDPA and PPA to dedicate resources to participants caring for disadvantaged populations that require greater investments in care. For example, dialysis facilities located a greater distance from transplant evaluation centers could receive add-on payments for travel and care coordination. Additionally, patients with housing instability may be disparately excluded from programs like Transition Care Units (TCUs) compared with other patients. Add-on payments for training of patients with housing instability could encourage the equitable inclusion of these patients into TCUs and other novel educational programs, thereby encouraging self-care dialysis and kidney transplantation. Prior to more widespread SDOH coding and reporting, dual-eligibility status or zip code–level data could be used in the interim for risk adjustment, as recommended by the National Academies of Sciences, Engineering, and Medicine. For instance, in 2019, the Hospital Readmissions Reductions Program introduced a stratified payment adjustment method, comparing hospitals within peer groups on the basis of percentage of dual-eligible patients; this has lessened penalties to safety net hospitals. A similar strategy could be applied to the ETC model to align incentives toward improving equity and limit potential “lemon-dropping.”

Third, incentives from ETC could be leveraged to develop feasible, innovative approaches to equitable care. The Department of Health and Human Services has previously concluded that “greater investments in health services required by those individuals who are sickest, most disabled and chronically homeless pays off in even greater cost offsets than can be gained by providing services . . . for (homeless) people . . . with less complex health and behavioral health problems.” For patients with HIV and homelessness, housing programs have decreased emergency department use and hospitalizations. Similarly, permanent supportive housing programs for patients with kidney failure could afford the same, if not greater, benefits. Participants could utilize the incentives proposed from the ETC model to partner with their local governments to prioritize subsidizing housing, housing vouchers, and dedicated programs for patients with kidney failure and housing instability. Participants could adapt transitional care units to include training for self-care dialysis, allowing an easier transition to home dialysis after housing is stable. Participants could partner with shelters to provide areas for self-care dialysis or cohorted assisted self-care dialysis. Participants could also invest in population health management to coordinate transplantation referrals, improve home dialysis education, coordinate transportation to appointments, and provide medication assistance. Taken together, if appropriately incentivized through payment adjustments, participants could partner with key stakeholders to empower patients with housing instability, reduce health care disparities, and potentially limit low-value health care utilization and costs.

Overall, the ETC model is another step in the right direction for innovation.
in kidney care. However, in the effort to advance American kidney health, we must equitably align care delivery and carefully consider SDOHs that affect our patients. Developing and implementing risk adjustment strategies for home dialysis could improve care delivery for patients with housing instability, among other SDOHs, and narrow the disparities in care. With input from the kidney community, we urge CMS to thoughtfully implement changes in incentives that promote equitable kidney care. Finally, lessons from ETC implementation should be leveraged to inform future policy to foster health equity in ESKD care.

**REFERENCES**


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