Dialysis Payment Model Reform: Managing Conflicts Between Profits and Patient Goals of Care Decision Making

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Dialysis patients represent <1% of all patients served by the US Centers for Medicare & Medicaid Services (CMS), but their treatments account for 7% of all CMS expenditures.[1] In 2014, total Medicare spending for beneficiaries with end-stage renal disease (ESRD) was nearly $33 billion. Care of dialysis patients near the end of life is particularly expensive, with median Medicare per-patient costs of $20,731 over the last 30 days of life.[1] Dialysis patients are hospitalized on average nearly twice per year and spend about 11 days in the hospital per year. Rates of rehospitalization are also high among patients treated with dialysis. Thus, reducing hospitalizations and other expensive health care interventions for dialysis patients creates opportunities for substantial savings. However, a new CMS payment model that aims to save costs of caring for patients receiving hemodialysis primarily through reducing hospitalization introduces major ethical risks that need attention.

Background

Payments for dialysis in the United States include reimbursements to the dialysis facility in which the patient is treated and, separately, professional fees to the nephrologist overseeing treatments. CMS is the primary payer for ~70% of US dialysis patients. Since reimbursement policy changes in 2011 that resulted in an expanded Prospective Payment System, CMS has paid dialysis facilities on a per-treatment basis for a bundle of care that includes the dialysis treatment, dialysis-related medications and laboratory tests, and capital-related costs attributed to providing dialysis treatments.[2] The base payment rate (subject to various adjustments) was $231.55 per treatment in fiscal year 2017. Although CMS payments are a major source of revenue for dialysis organizations, they reportedly contribute little to their profit.[3] Most dialysis facility profits instead come from commercially insured patients. The mean outpatient dialysis facility margin from Medicare payments was ~0.4% in 2015. In general, facilities with higher treatment volumes have higher profit margins.[4]

Nephrologists are paid separately by Medicare through a monthly capitated payment system that provides progressively higher reimbursements for 1, 2 to 3, or 4 documented face-to-face visits per patient per month for patients receiving maintenance in-center hemodialysis, with median monthly reimbursement rates in 2017 of $185.91, $241.18, and $287.12, respectively. Because payments for long-term dialysis services are not subject to physician self-referral prohibitions, nephrologists are also able to derive income from ownership or "joint venture" investments in outpatient dialysis facilities. Under joint venture arrangements, individual nephrologists or nephrology practices invest in the development and opening of a new dialysis facility as a minority investor, sharing in facility profits. Thus, our current payment structure tends to financially reward utilization of dialysis treatments through facility reimbursements, professional fees (the monthly capitated payment), and ownership or joint venture investment when dialysis facilities are profitable.

ESRD Seamless Care Organizations

In 2015, CMS began testing whether a new Comprehensive ESRD Care payment model, based on creation of accountable care organizations (ACOs) called ESRD Seamless Care Organizations (ESCOs), would reduce costs and improve outcomes for Medicare dialysis beneficiaries.[5] ESCOs are legal partnerships in which dialysis facility owners, nephrologists, and others are expected to explore new ways to provide enhanced services for dialysis beneficiaries and reduce hospitalizations, while being held accountable for clinical and financial outcomes. There are currently 37 ESCOs participating in this demonstration project. ESCOs may lose or gain financially depending on clinical outcomes and performance on quality metrics and on total health care costs incurred by their patients,[6] with financial responsibility for costs of all

Policy Forum highlights aspects of nephrology relating to payment and social policy, legislation, regulation, demographics, politics, and ethics, contextualizing these issues as they relate to the lives and practices of members of the kidney community, including providers, payers, and patients.

care excluding Medicare Part D prescription medication and transplantation-related costs, not just dialysis treatments. This includes hospitalizations, which account for ~40% of Medicare expenditures for dialysis patients.[1] Non-Medicare patients are excluded from ESCOs.

ESCOs operated by larger dialysis organizations (≥200 owned dialysis facilities) are held to 2-sided risk-based payments, benefiting from shared savings payments if the ESCO does well financially (provided minimal quality metrics are met), but being held accountable for a portion of losses if it does not. Smaller dialysis organizations (<200 facilities) have the option of being held to a 1-sided risk-based payment with only shared savings opportunity and no downside financial risk or a 2-sided track similar to that of the larger organizations. Eligibility for shared savings after the first year is dependent on achievement of CMS-determined thresholds for quality performance, which are partially based on the ESRD Quality Incentive Program.

Integrated Care Organizations, Conservative Care, and New Ethical Risks

This new CMS payment model, in which financial success is largely dependent on hospitalization reduction, will change existing incentives to provide dialysis to as many patients as possible, but also introduces serious and complex new ethical risks regarding goals of care and end-of-life considerations. The main concern is that dialysis providers and physicians in ESCOs will respond to these new incentives by preferentially pushing certain patients toward conservative care or hospice in order to avoid hospitalization costs to the ESCO. Similar risks are likely to arise in future versions of integrated care organizations developed to manage costs and improve outcomes for patients with kidney disease. Ethical challenges for leaders, clinicians, and patients involved with primary care ACOs have also been noted, included that of perceived pressure to withhold care to aid ACO finances.[7]

Nephrologists increasingly recognize the value of conservative management without dialysis and hospice for patients with advanced chronic kidney disease (CKD) or ESRD,[8] although the knowledge and resources to provide optimal end-of-life care for these patients are often lacking.[9,10] Among older adults in particular, the intensity of health care when dialysis is initiated can be high[11,12] despite the often limited quality of life and survival for such patients.[13] In the United States, 30% of incident hemodialysis patients 75 to 89 years old die within 1 year.[13] Hospitalization rates are particularly high near the end of life for many dialysis patients, with hospice care often underused.[1,12,14,15]

Reducing overall hospitalizations for dialysis patients is a laudable goal. However, one way to accomplish this is to identify patients who are frequently hospitalized and encourage them to stop dialysis in favor of hospice. Clearly, some patients remain on dialysis when it offers little in the way of improving quality or quantity of life. For those with substantial cognitive and physical infirmities, dialysis may be more a burden than a benefit. Stopping dialysis with use of palliative care and hospice may be in the best interests of these patients. However, serious ethical conflicts arise when decisions about avoiding or stopping dialysis can enhance the financial success of dialysis facility owners and other ESCO investors. In the Medicare ESCO payment model, which rests on trade-offs between little or no financial gain for providing dialysis versus avoiding potentially significant financial losses due to high hospitalization costs, the latter will tend to be the dominant factor determining ESCO profitability. Likewise, nephrologists invested in an ESCO may weigh the benefit of receiving relatively modest professional fees for continuing to provide dialysis against the risk for financial losses to the ESCO when patients are hospitalized.

To further complicate matters, companies that own dialysis units, including almost all those participating in ESCOs, are moving "upstream" and reaching out to patients with non–dialysis-dependent CKD for education and other services.[16] This expanded role creates additional ethical conflicts if employees of such facilities, rather than the patient's nephrologist and other physicians, guide patients with CKD with high hospitalization risk to conservative nondialytic management or hospice instead of dialysis, thus avoiding costs related to hospitalizations for the ESCO. A large dialysis provider recently described a proposed process for a comprehensive conservative care program for patients with CKD.[16] In this program, a care coordinator employed by the dialysis provider educates patients about conservative care, serves as an advocate for patients to explain that "comprehensive conservative care is a reasonable clinical decision,"[16,p129] and, if requested by the patient, arranges for palliative care and hospice. The role of the nephrologist and primary care physician in these discussions is not delineated. The authors highlight cost savings from the program, noting that the average cost of conservative care is nearly $50,000 less annually than dialysis. However, assessing the cost-effectiveness of supportive care for patients with advanced kidney disease must also consider quality of life, functional status, patient preferences, and health care resource utilization.[17]

Potential Strategies to Manage Ethical Problems Driven by Changing Financial Incentives

Ideally, discussions among patients, families, and their health care providers about conservative and palliative care should be free of conflicts of interest. Unfortunately, conflicts of interest may be impossible to avoid and, as noted, influence patient care both with our current fee-for-service reimbursement system and in newer integrated models. However, there is a fundamental difference between the ethical duties and responsibilities of physicians compared with employees of dialysis companies participating in ESCOs or other future dialysis integrated care organizations. Nephrologists have professional