

Addressing Financial Disincentives to Improve CKD Care

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J Am Soc Nephrol 29: ●●●–●●●, 2018. doi: <https://doi.org/10.1681/ASN.2018040438>

The annual cost to Medicare for a patient receiving dialysis is close to \$88,000, about three-fold higher than the cost of a patient with CKD stages 4–5.¹ Over the past decade, until very recently, the percentage of patients in the United States initiating dialysis with eGFR levels >10–15 ml/min per 1.73 m² increased steadily despite randomized, controlled trial and other evidence indicating that there is no benefit, and perhaps even harm, to initiating dialysis prematurely.² There are no financial incentives or quality measures encouraging providers to maximize their efforts to slow CKD progression or delay initiation of dialysis until truly necessary, even though doing so would decrease health care costs and improve quality of life for many patients. Patients with advanced CKD, especially those nearing ESRD, are complex and usually need a multidisciplinary care strategy that requires a substantial amount of investment and infrastructure. However, because caring for patients on dialysis reimburses physicians more than caring for patients with CKD,³ physicians may not feel incentivized to make this investment. Likewise, providers have no incentive to offer conservative care without dialysis when appropriate and preferred by the patient.⁴ The absence of CKD-specific quality measures further limits opportunities for providers to assess and improve the care they provide.

DISINCENTIVES TO OPTIMAL CKD MANAGEMENT

Once a patient with Medicare commences dialysis, the Centers for Medicare and

Medicaid Services (CMS) pays the treating nephrologist a monthly capitated payment (MCP) ranging from approximately \$188 to \$388 per month for overseeing the outpatient dialysis care. In contrast, for patients with CKD not on dialysis, CMS and other insurers pay for office visits on a fee-for-service basis, with the most complex return office visit reimbursed at approximately \$148 a visit. Thus, the MCP for dialysis is substantially higher than the payments for CKD office visits. This payment disparity could create an adverse incentive for nephrologists to recommend starting dialysis early, even when it might not be necessary or in patients' best interests.

The current reimbursement structure also limits providers' ability to invest in the infrastructure necessary to take excellent care of patients with advanced CKD, which is often as or more difficult and time-consuming than taking care of patients once they have started dialysis. Effectively managing progressive CKD, regardless of etiology, requires a multidisciplinary effort to address hypertension and other associated comorbidities, manage a lengthy medication list, treat anemia and bone-mineral metabolism disorders, address nutrition, maintain fluid and electrolyte homeostasis, and coordinate care with primary care and other specialty physicians. The nephrologist must also guide patients through dialysis planning, access placement, early transplant referral, and conservative care options. This limited reimbursement for CKD care discourages providers from utilizing social workers, dietitians, pharmacists, and nurse educators, who are often necessary for optimal

CKD care. On the other hand, dialysis units have a plethora of multidisciplinary resources and built-in care pathways for managing complications common to patients with ESRD. Thus, starting a patient with late-stage CKD on hemodialysis may be a "path of least resistance," that is, to place a catheter and commence dialysis treatments rather than continue complex and time-consuming, office-based CKD care.

AN OPPORTUNITY FOR PAYMENT REFORM

Improving office-based health care for late-stage CKD requires an upfront investment and may increase CKD care costs. However, Medicare and other payers would likely realize overall savings by preventing hospitalizations,⁵ delaying the onset of dialysis, and avoiding associated dialysis costs such as access placement, hospitalization for initiation of dialysis, and dialysis facility treatment payments.⁶ Every patient-month of delayed or avoided dialysis could save Medicare close to \$5000 per patient per month, or \$60,000 per year.¹

Published online ahead of print. Publication date available at www.jasn.org.

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One potential avenue for financially rewarding high-quality, cost-efficient care for severe CKD is through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).⁷ Providers may participate in MACRA either through the Merit-based Incentive Payment System (MIPS) or an Advanced Alternative Payment Model (AAPM). Most providers will participate in MACRA through the MIPS because of the steep infrastructure requirements for AAPMs. The MIPS maintains the Part B fee-for-service system but evaluates providers using quality and cost metrics.⁸ Although quality measures could encourage increased investment in CKD care, they cannot address financial disincentives implicit in CKD reimbursement. Some of these pressures can be alleviated through the MACRA-mandated creation of episode-based cost measures that hold providers accountable for the costs of treatment, aftercare, and complications associated with a clinical condition. A CKD episode that incorporates the downstream costs of hospitalizations, dialysis, access infections, and transplant would reward providers who effectively prevent hospitalizations or premature dialysis initiations.

However, quality and cost measures are unlikely to eliminate the “start dialysis” incentive because of the MCP for ESRD. Creating a competing “invest in CKD” incentive would likely require payment reform that reduces the tremendous disparity between CKD-related physician reimbursements and the MCP. One way to reform CKD payment is establishing a per member, per month (PMPM) payment in lieu of office visit reimbursement to nephrologists taking care of Medicare beneficiaries with advanced CKD (e.g., eGFR \leq 20 ml/min per 1.73 m²). This added payment would afford nephrology practices the means to develop an interdisciplinary infrastructure. CMS could also require, after discussion with various stakeholders (nephrology professional organizations, patient advocacy groups, nephrologists, and patients), that PMPM providers achieve appropriate patient-centered outcomes such as

slowing CKD progression, reducing hospitalizations, addressing multimorbidity through improved care coordination with primary care and specialists, and optimizing the CKD-to-ESRD transition, including conservative care without dialysis when appropriate (Table 1). Focusing on patient-centered outcomes could give providers the flexibility to determine the multidisciplinary services most appropriate for their specific patient population. Improved dialysis transitions may also reduce the use of hemodialysis catheters and increase home dialysis use and preemptive transplantation.⁴

This type of upstream investment by the CMS would dovetail well with quality and episode-based cost measures. Although a PMPM payment would add upfront costs to CKD care, it could yield substantial savings to Medicare overall through the prevention of high-cost complications common to late-stage CKD. Averting a single hospitalization or delaying dialysis by just a few months could cover PMPM costs and result in financial benefits to nephrology practices, Medicare, and other payers, as well as improving patient outcomes.

Some providers will have the capital needed to form CKD AAPMs that more formally operationalize a multidisciplinary approach to high-quality, coordinated care. CMS incentivizes cost-efficient care in most AAPMs by creating opportunities for shared savings (and in many cases, shared losses) through increased payment in turn for better quality and reduced

health care costs.⁸ An AAPM could be reimbursed through a PMPM structure and would provide yet another opportunity to improve late-CKD care. A recent analysis suggested that a Medicare-funded multidisciplinary care program for mild-to-moderate CKD would meet conventional cost-effectiveness thresholds.⁹ Although an aggressive multidisciplinary care AAPM would cost per patient close to \$2000 annually, or roughly \$165 per month (more than current reimbursements for office visits), the program could reduce overall Medicare spending by preventing major CKD cost items.

CKD QUALITY MEASURES TO COMPLEMENT A NEW PAYMENT MODEL

Although CMS has implemented an array of quality measures for ESRD, there are few measures specific to CKD and none that focus on care coordination or the prevention of costly events like hospitalizations or early initiation of dialysis. Developing CKD-specific measures that complement payment reform could establish incentives for slowing CKD progression and ensure that providers use their financial resources to improve patient health and practice high-value care. Potential quality measures for CKD include process measures like the percentage of patients with documented medication reconciliation, timely vaccinations, and transplant

Table 1. Possible services that could be required for multidisciplinary CKD management

Possible Services
Office visits, face-to-face or via telehealth services, and management of certain comorbidities
Dietitian services
Pharmacy services, medication reconciliation
Care coordination with primary care providers, other specialists
Screening for depression and anxiety
Access to social services
Recommended immunizations
CKD, dialysis modality, and transplant education
Advance care planning with palliative/conservative care coordination if indicated
Vascular or peritoneal dialysis access placement
Transplant evaluation
Outpatient dialysis initiation when appropriate

evaluation when appropriate; patient-reported measures; and outcome measures like hemodialysis starts with arteriovenous access, standardized hospitalization ratios, and 30-day readmission rates. Many of these measures could be adapted from the ESRD Quality Incentive Program or the Comprehensive ESRD Care Model.¹⁰

CONCLUSIONS

We suggest that CMS initially implement a CKD payment reform pilot program in patients most likely to benefit, such as those with high levels of albuminuria and $eGFR \leq 20$ ml/min per 1.73 m^2 who are not in imminent need of RRT. Such a program would allow CMS to empirically test the effect of multidisciplinary care on patient health and health care spending. A pilot program would also allow CMS to determine the feasibility of these programs in different types of nephrology practices. Simultaneously, careful claims-based attribution and development of risk-adjusted cost and quality measures is paramount and would minimize risk selection through “cherry picking” of less complex patients. Given the disproportionate share of ESRD costs in Medicare, a trial with Medicare patients seems justifiable, although such an approach could easily be undertaken by other payers. Realigning payment incentives to focus on the health of patients with CKD has the potential to benefit

CMS by reducing costs, nephrology providers by enhancing their ability to care for patients with CKD, and most importantly, patients as recipients of comprehensive, coordinated, and multidisciplinary care that avoids dialysis until essential.

ACKNOWLEDGMENTS

E.L. is supported in part by the National Institutes of Health through a National Institute of Diabetes and Digestive and Kidney Diseases grant: F32DK107123. T.L.S. is employed by the National Kidney Foundation.

The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health or the National Kidney Foundation.

DISCLOSURES

None.

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