

Social Risk and Dialysis Facility Penalties Under the End-Stage Renal Disease Quality Incentive Program

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KEY FINDINGS

- Dialysis facilities located in low-income ZIP codes and with high proportions of Black or dually enrolled Medicare and Medicaid patients had lower performance scores and higher penalties under Medicare’s ESRD QIP.
- The ESRD QIP could cause facilities to avoid caring for high-risk patients that are perceived to be likely to have negative outcomes measured under the program.
- Penalties imposed on dialysis facilities in low-income ZIP codes could worsen facility quality by taking away valuable resources.
- The ESRD QIP penalties could also spur facilities to improve quality, which could reduce disparities.
- The impact of the ESRD QIP needs to be closely monitored to ensure the program is as equitable as possible.

Introduction

Introduced in 2012, Medicare’s End-Stage Renal Disease Quality Incentive Program (ESRD QIP) is a mandatory pay-for-performance program for U.S. dialysis facilities that penalizes facilities up to 2% of their Medicare payments based on their performance on a set of quality measures, including infection rates, readmission rates, and patient experience scores. Analyses of similar programs in other settings, such as hospitals and outpatient clinics, have shown that safety-net providers are more often penalized under these programs, which could have negative consequences for vulnerable populations.¹⁻³

This research investigates whether the ESRD QIP was more likely to penalize dialysis facilities that serve vulnerable populations.

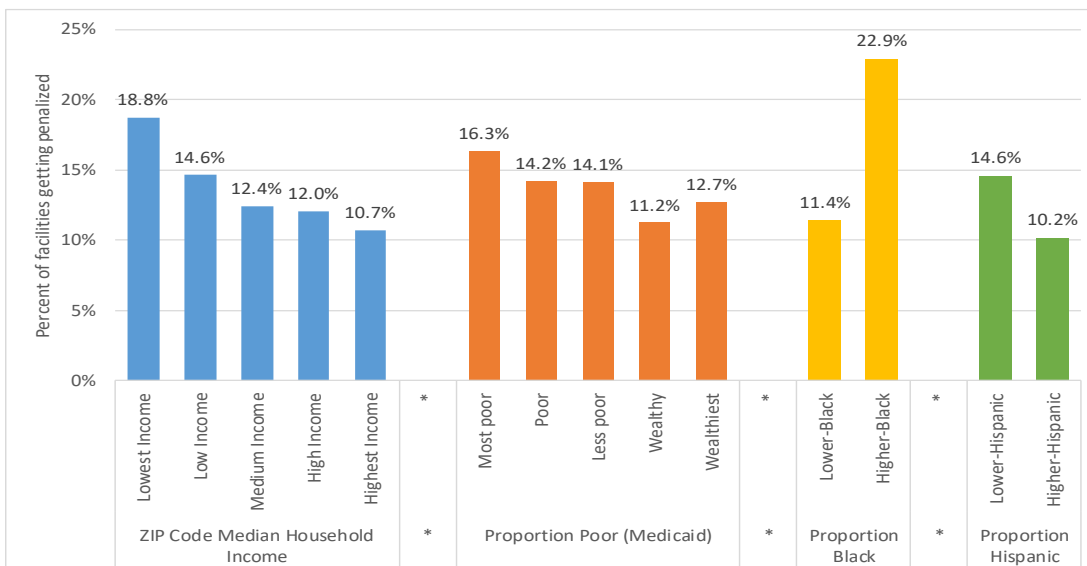
Data and Methods

We analyzed data on 6,314 dialysis facilities nationwide using publicly available data from Medicare for the 2018 ESRD QIP payment year. Using statistical models, we determined whether facilities with a high proportion of patients who were poor, racial or ethnic minorities, or located in an impoverished neighborhood, had higher penalties under the program. We controlled for other characteristics like facility size, ownership, and region.

Results

There were 6,314 dialysis facilities in the program. On average, about 19% of the patients at these facilities were Black, and around 5% were Hispanic. Roughly a third were enrolled in both Medicare and Medicaid, which we use as a marker for poverty. Dialysis facilities in areas with lower neighborhood median income (measured at the ZIP code level) and facilities with more Black and dually enrolled beneficiaries had lower scores (meaning they did worse on the performance measures) and were more likely to receive penalties (Figure 1).

Figure 1. Likelihood of penalization under the ESRD QIP by social risk factor.

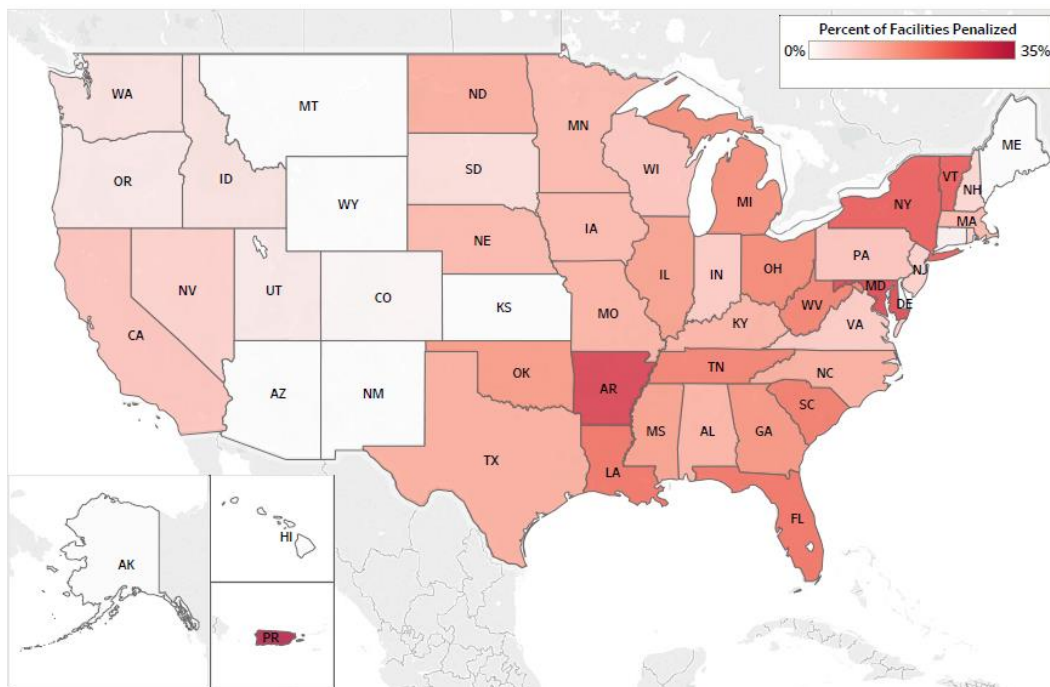


Results (cont'd)

For example, 18.8% of dialysis facilities in the poorest neighborhoods were penalized, compared with 10.7% in the wealthiest neighborhoods (blue bars in Figure 1). Only 11% of facilities with lower proportions of Black patients received penalties, compared with 22.9% of facilities with the highest proportions of Black patients (yellow bars in the Figure 1).

Penalties also varied significantly by state, with the proportion receiving penalties ranging from 0% (several states) to 35% (Puerto Rico) (Figure 2).

Figure 2. ESRD QIP Penalties by State, 2018.



Policy Implications

The ESRD QIP disproportionately penalizes dialysis facilities serving the most vulnerable populations. The consequences of this program are crucial to monitor.

On one hand, low scores may be due to poor quality dialysis care delivered to vulnerable populations, and penalties under the ESRD QIP could spur facilities to improve quality. On the other hand, low scores are in part related to patient factors that are out of the control of the facilities – for example, readmissions for conditions that have nothing to do with the quality of patients' dialysis care – and therefore financial penalties could worsen quality by taking resources away from the facilities that need them most. Another unintended consequence is if the program creates an incentive to avoid caring for high-risk patients that are perceived to be likely to have negative outcomes measured under the program. This risk aversion has been seen in other programs.^{4,5}

One way to decrease these adverse consequences would be to adjust the quality measures for social risk factors such as poverty. The program could also be restructured so that facilities are compared to other similar facilities. Additional support for quality improvement should also be targeted to the facilities serving the most vulnerable patients.

Overall, these findings have implications for clinicians and policymakers seeking to target interventions to improve care and seeking to ensure the ESRD QIP is as equitable as possible.

¹ Fiscella K, Burstin HR, Nerenz DR. JAMA. 2014;312(24):2615-2616. <https://jamanetwork.com/journals/jama/fullarticle/2084900>

² Joynt KE, De Lew N, Sheingold SH, Conway PH, Goodrich K, Epstein AM. N Eng J Med. 2017;376(6):510-513. <https://www.nejm.org/doi/full/10.1056/NEJMp1616278>

³ Casalino LP, Elster A, Eisenberg A, Lewis E, Montgomery J, Ramos D. Health Affairs. 2007;26(3):w405-w414. <https://www.healthaffairs.org/doi/10.1377/hlthaff.26.3.w405>

⁴ Blumenthal DM, Valsdottir LR, Zhao Y, Shen C, Kirtane AJ, Pinto DS, et al. JAMA Cardiol. 2018 Jul 1;3(7):629-34. <https://jamanetwork.com/journals/jamacardiology/fullarticle/2680626>

⁵ Joynt KE, Blumenthal DM, Orav EJ, Resnic FS, Jha AK. JAMA. 2012 Oct 10;308(14):1460-8. <https://jamanetwork.com/journals/jama/fullarticle/1377923>