

IV. SANCTION RECOMMENDATIONS

Public 98-369 amends Section 1881(c) of the Social Security Act states; the Network Organization can recommend to CMS the imposition of an alternative sanction when the Network Organization documents that an ESRD provider is not cooperating in meeting Network goals and objectives. The Federal Regulations that implement this statute are contained in 42CFR 405.2181.

The philosophy of Network #1 has always been to foster partnerships and cooperation with the renal community (ESRD providers) to seek collaborative methods to improve patient care. This Network continues to offer technical assistance, quality improvement coaching and educational venues for professionals to enhance their ESRD knowledge and skill set. The Network Board of Directors and Medical Review Board review coded comparative provider information to determine patterns of performance in quality and information management. When indicated, Network #1 has conducted focused intervention with the leadership of specific providers, which have been responsive to addressing the identified areas of concern. During 2007 no sanctions were recommended to CMS regarding any ESRD provider in this Network region.

V. RECOMMENDATIONS FOR ADDITIONAL FACILITIES

Challenging Patients

The increasing number of challenging or disruptive patients requires unique staff communication and interpersonal skills. Consideration, by CMS, of “unique needs” dialysis clinics with additional provider reimbursement, to allow for a different staff to patient ratio, would reduce the number of patients experiencing an involuntary discharge from dialysis units. This Network continues to recommend a pilot project be developed to test the feasibility of this type of dialysis model.

Acute Outpatient Dialysis

There are a small number of medically stable patients that require a course of short-term dialysis (non-chronic) in outpatient dialysis programs, usually requiring less than 3 months of dialysis. The increased pressure from managed care plans and shorter in-patient hospital stays has created this new patient population. The Network recommends that CMS develop Medicare billing codes for this patient population and consideration be given to future policy issues for these non-chronic ESRD patients requiring short-term outpatient dialysis treatments. The current system of Medicare payments for acute outpatient dialysis to only hospitals is not a workable solution since most of these patients are treated in freestanding dialysis clinics. Having acute renal failure patients travel to hospitals with ESRD provider certification is a hardship, or impossible due to very limited access to hospital owned ESRD providers.

Hospital Based Providers

This Network has observed, during the past few years, a major change in type of ownerships of ESRD outpatient programs. Currently, there are only 30 (18%) hospital owned ESRD programs in New England (Table Q). These hospital facilities have a unique patient case mix due to restricted admission criteria by freestanding facilities. The burden of uninsured and patients with complex medical conditions places extra financial and staff pressure to provide needed dialysis services. CMS should convene a Technical Advisory Panel to investigate these patient case mix issues. Pay for Performance will only increase these access to dialysis service barriers.

Table Q: Dialysis Providers by Ownership
12/31/2008

	For Profit chain	VA Hospital	Hospital	Independent	Total
CT	32	1	3	1	37
MA	52	1	14	9	76
ME	10	1	5	2	18
NH	9	0	0	1	10
RI	15	1	2	0	18
VT	0	0	6	1	7
Total	118	4	30	14	166
Percent	71%	2%	18%	8%	100%

Note: Dialysis Clinic Inc. is a national chain that is non-profit. These providers are listed in the Independent column.

Dialysis Nurses

The ongoing challenge of finding skilled dialysis nurses to work in dialysis clinics is creating an access to dialysis services hardship in some renal communities. This Network encourages CMS to seek incentives to attract nurses to the ESRD program.

Access to ESRD Medicare Benefits Due to the Establishment of SIMS

A few years ago, the process of completing the Medical Evidence Entitlement and Registration Form (Form 2728) was changed. This electronic process requires the ESRD provider to complete Form 2728. Therefore, patients with long complicated hospitalizations that became ESRD and start a regular course of dialysis while in the hospital are unable to get the Form 2728 initiated. They must be discharged or transferred to an outpatient dialysis provider to begin the application process. The launching of CROWNWeb in 2009 will only increase this access to Medicare benefits barrier for new ESRD patients. This is an unintended complication of data driven electronic technology that CMS should address.