IV. SANCTION RECOMMENDATIONS

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

The philosophy of Network 1 has always been to foster partnerships and cooperation with 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 sets. 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 interventions and performed site visits with the leadership of specific providers. These providers and their Medical Directors have been responsive to addressing the identified areas of concern. In 2010, Network 1 initiated a more aggressive quality improvement agenda by giving specific provider-level clinical goals for AVF rates. In addition, a few indentified providers were given written CMS notice of performance concerns related to their AVF rate. During 2010, no sanctions were recommended to CMS regarding any ESRD providers in this Network region.

V. RECOMMENDATIONS FOR ADDITIONAL FACILITIES

The following concerns were noted in the 2009 Annual Report. These issues remain unaddressed and continue to exist.

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 higher staff-to-patient ratios, would reduce the number of patients experiencing involuntary discharges from dialysis units. This Network once again recommends a pilot project be developed to test the feasibility of this dialysis treatment model.

Acute Outpatient Dialysis

There are a small number of medically stable patients who require a short-term course of dialysis in an outpatient dialysis program, usually requiring less than 3 months of dialysis. The increased pressure from managed care plans and shorter inpatient hospital stays has created this new sub-acute renal patient population. The Network recommends that CMS develop Medicare billing codes for this patient population. Consideration by State Departments of Public Health (DPH) and CMC should address policy issues for these non-chronic ESRD patients requiring short-term outpatient dialysis treatment. The current system limiting Medicare payments for acute outpatient dialysis to hospitals is a complicated process since most of these patients are treated in freestanding dialysis clinics. A stakeholders committee with CMS and DPH representatives should be established to seek a more effective, clearer payment process.

Hospital-Based Providers

This Network has observed, during the past few years, a major change in type of ownership of outpatient dialysis facilities with the majority of free standing facilities owned by large dialysis for-profit corporations. Currently, there are only 31 hospital-owned dialysis facilities (18% of all dialysis facilities) in New England (Table V). These hospital facilities have a unique patient case mix due to complex acuity levels of these patients. The burden of uninsured and patients with complex medical conditions places extra financial and staff pressure to provide needed dialysis services. Medicare bundled payment may decrease these dialysis service barriers.

Table V: Dialysis Providers by Ownership 12/31/2010

	National Chain	VA Hospital	Hospital	Independent	Total
CT	37	1	3	0	39
MA	58	1	14	3	76
ME	12	1	5	0	18
NH	11	0	0	1	11
RI	13	1	3	0	17
VT	1	0	6	1	8
Total	**132**	**4**	**31**	**5**	**172**
Percent	**76%**	**2%**	**18%**	**4%**	**100%**

Note: Percents may not equal 100% due to rounding

Access to ESRD Medicare Benefits Related to Administration of Form 2728

A few years ago, the process of completing the Medical Evidence Form (Form 2728) was changed. This electronic process requires the form to be completed by the ESRD provider. Therefore, patients with long complicated hospitalizations who start a regular course of dialysis while in the hospital will not have Form 2728 initiated. The patient must be discharged or transferred to an outpatient dialysis provider to begin the application process, delaying their access to Medicare ESRD benefits. The launching of CROWNWeb in 2011 will only increase this access barrier for new ESRD patients. This is an unintended complication of electronic technology that CMS should address.