Good morning Mr. Chairman and Members of the Special Committee on Aging. My name is Terry Bahr, and I am the Administrator at Scripps Dialysis Center, which operates 2 free-standing for-profit dialysis facilities in LaJolla, California. I am currently the President of the National Renal Administrators Association (NRAA).

The NRAA is a voluntary organization representing professional managers of dialysis facilities and centers throughout the United States. We represent free-standing and hospital-based facilities, which are for-profit and non-profit providers located in urban and rural areas. Our members manage approximately half of the dialysis units in this country which provide dialysis services to a majority of Medicare End-Stage Renal Disease (ESRD) patients. The association was founded to provide information and education to our members and to work with the Congress, the Administration, and other oversight organizations on the Medicare ESRD program. Our organization is dedicated to providing quality of care to the ESRD patients in our dialysis facilities in the most cost effective manner. The association is also dedicated to educating our membership on complying with all of Medicare's rules and regulations.

We are delighted to have the opportunity to participate in this important hearing on the Medicare ESRD program. Our testimony will focus on: (1) NRAA's position on quality of care provided by Medicare's ESRD program, (2) HCFA's oversight of the program, (3) NRAA's suggestions for improvements within the ESRD program, and (4) the association's numerous initiatives directed at improving the quality of care dialysis patients receive.

Medicare ESRD Program Is Successful, Cost Effective and Improving Quality of Care

The Medicare ESRD program has been highly successful in providing access to life sustaining quality care to over 90 percent of individuals with end-stage renal disease in this country. The Institute of Medicine, in its landmark study entitled, ***Kidney Failure and Medicare Program***, concluded that, "It (i.e. Medicare's ESRD program) has been remarkably successful in fulfilling its intended objectives."

This program has also been extremely cost effective as explained in the latest United States Renal Data System (USRDS), ***1999 Annual Data Report.*** According to this report, while real Medicare payments per year for ESRD continue to rise in response to a growing ESRD population, nominal spending per patient per year actually decreased by 0.2% in 1997 and in the past several years there has been little or no growth in per patient spending.

Despite almost two decades of declining Medicare reimbursement both in real and inflation adjusted dollars, dialysis providers have been improving the quality of care to the estimated 300,000 ESRD Medicare beneficiaries in this country. The USRDS ***1999 Annual Data Report*** demonstrates that dialysis facilities have been improving mortality rates. Also, the ***1999 Annual Report on ESRD Clinical Performance Measures Project*****,** published by HCFA, shows steadily improving numbers on the adequacy of dialysis and anemia management, two key measures of quality of care for dialysis patients.

However, the NRAA strongly believes that if dialysis providers are to continue making progress in improving quality of care in their facilities Medicare needs to do a better job of reimbursing dialysis facilities for providing the treatments that lead to improved outcomes.

Need to Include An Annual Inflation Formula to Medicare's Dialysis Payments

The Medicare Payment Assessment Commission (MedPAC) essentially agrees with the NRAA's and renal coalition's position. MedPAC, in their ***March 2000 Report to the Congress***, recommends that HCFA annually review the composite rate paid to dialysis facilities because currently all but the largest

dialysis providers are being reimbursed by Medicare at a payment rate that is **less** than their costs. Further improvements in quality will entail more resources as improving quality is an intensive process requiring staff to do more in terms of patient education, monitoring, services and rehabilitation.

MedPAC would agree that dialysis facilities are about as productive and efficient as possible and therefore it is unrealistic to expect dialysis facilities to be able to do more at current Medicare reimbursement levels.

Unfortunately, HCFA has no authority to annually update the composite rate, as it does for all other Medicare providers. However, Congress could mandate that they be required to do so.

The NRAA would urge members of this committee to join Senators Frist and Conrad, in introducing legislation to support MedPAC's recommendations to increase payments to dialysis facilities by an additional 1.2% in 2001 and require HCFA to provide an annual inflation update to dialysis facilities, beginning in 2002.

HCFA's Oversight of the ESRD Program

The NRAA has supported HCFA's efforts to improve quality through their Continuous Quality Improvement (CQI) Initiatives, including the National Anemia Study, Core Indicator Study and now the ESRD Clinical Performance Measures Project. These projects have provided dialysis facilities specific data on how well each facility is doing in improving the adequacy of dialysis, anemia and other quality measures. The USRDS, funded by the NIH, also provides facility specific profiling data. The association believes that these types of profiling data have significantly improved the quality of care in facilities.

NRAA's Suggestions for Improvements Within the ESRD Program

While the NRAA believes HCFA has made an honest effort to help improve quality of care in dialysis facilities, the association would like to make the following recommendations for additional improvements:

1. **HCFA should do a better job of ensuring that the state surveyors are well trained and understand the dialysis regulations**. In some states the surveyors are very knowledgeable but in others they do not understand the ESRD regulations and as a result sometimes unfairly cite dialysis facilities because they have misinterpreted the rules. Lack of adequate training also frequently results in variations and inconsistencies in interpreting the guidelines among the states which creates unjustified problems for providers with facilities in more than one state.

2. **HCFA should require greater collaboration between the 18 ESRD Networks and state survey agencies**. This would help target the limited resources available to helping problem dialysis facilities improve the quality of care in their facilities.

3. **HCFA should require the state surveyors in general to survey dialysis facilities every three years**. The state agencies should identify problem dialysis facilities and target them for more frequent inspections. For dialysis facilities that have been found to provide good quality care, the state surveyors should only conduct brief surveys in the next third year survey, so that they can spend the bulk of their time on the problem facilities.

There are other ways in which HCFA could assist the renal community in improving quality care.

1. **HCFA should be required to respond in a more timely fashion to issues that are critical to the ESRD industry**. For example, it took HCFA well over a year to respond to the association's request for guidance and clarification of the rules concerning ESRD Medicare beneficiaries in skilled nursing facilities (SNFs), due to the implementation of the SNF prospective payment system. Another example was the renal community's request for continued separate reimbursement for doppler flow studies. It took HCFA three years from the time of our first meeting with them on this issue to publish a program memorandum which we now find unacceptable. The NRAA members have a steady stream of questions for HCFA on reimbursement issues that directly or indirectly affect quality of care. HCFA should have to respond to such questions within thirty days rather than the months and sometimes years before answers are given.

2. **HCFA should allow dialysis providers to utilize and be reimbursed for new technologies instead of continually claiming that they are already included in the composite rate paid to dialysis facilities**. The latest example concerns doppler flow studies, which are used to measure the dialysis vascular access. If the vascular access is blocked or in any way narrowed it is very difficult to adequately dialyze a patient. Instead of establishing a national policy on the medical justification for separate reimbursement for doppler flow studies, HCFA is leaving it up to each local fiscal intermediary according to their Program Memorandum Transmittal AB-00-44. As a result, some patients' care will be compromised because the local intermediary has not made a decision on when or if reimbursement will be made. Dialysis facilities cannot afford to provide this service without separate reimbursement given that the composite rate paid to dialysis facilities has essentially been frozen for the past two decades.

3. **Require better coordination between the different departments of HCFA that handle ESRD issues**. The latest reorganizations have resulted in such fragmentation that it is very difficult to know who in HCFA is handling an issue and to get all the necessary players at HCFA to coordinate their policies. This fragmentation has also led to confusion and lack of clarification on what Medicare's rules are which in turn means that dialysis facilities have to spend too much time on administrative issues which detracts from their time spent on improving quality of care.

4. **HCFA should be given the authority to require physicians to physically see their patients at least two times a month in the dialysis unit or in their offices**. Physicians should also be required to participate in patient care planning on a monthly basis for unstable patients and every six months on stable patients in order to qualify for their monthly capitation fee.

Having made the above recommendations, the NRAA would still say that the best way to monitor and improve quality of care of ESRD patients in dialysis facilities is to utilize the existing ESRD Network structure. Dialysis facilities should have to report data on renal community consensus outcome measures to their Network and the Networks should work with facilities that are below the average for their area, state or nationally to improve the care their patients receive. Renal administrators have found that this system works best in turning problem facilities into facilities that provide their patients with first rate care.

NRAA's Initiatives to Improve Quality of Care for Dialysis Patients

The NRAA has taken many steps since the inception of the association to improve the quality of care in dialysis facilities. **First, the NRAA has worked with other organizations in the renal community to reach consensus on how to improve quality of care by establishing quality measurement guidelines**. The best examples of this are the establishment of the Dialysis Outcome Quality Initiatives known as DOQI and KDOQI, which spell out for the first time guidelines for measuring adequacy of dialysis, and establishes other outcomes measure guidelines. NRAA not only participated in the development of these outcome measures but has had several speakers at spring and annual meetings

educate renal administrators on how to implement these outcome guidelines.

Secondly, the NRAA allots considerable time at each spring and annual conference to having a variety of experts educate the membership on the newest quality standards. For example, when new water quality standards are established by the American Association of Medical Instrumentation (AAMI), the NRAA had someone from the organization speak about the new standards. The association has also helped sponsor AAMI workshops on water quality standards for dialysis facilities. The association also regularly has experts talk about re-use of dialyzers and one of our members has begun the first partnership with a company to centralize the cleaning and sterilizing of re-used dialyzers which is hoped will prove to be a cost effective and quality enhancing program for re-using dialyzers. Another NRAA member is currently participating in a research project on re-use.

As compliance with Medicare's numerous and complex rules is another key to improving quality of care, the NRAA undertook to develop a compliance manual for dialysis facilities. The association is now selling its compliance manual to administrators and others in the renal community and has held two compliance workshops, with more to follow.

The NRAA has also had a long standing interest in improving the data supplied on Medicare cost reports and annually holds cost report workshops. The NRAA has been credited by MedPAC with improving the quality of data reported on cost reports. This is important because without accurate cost data, policy makers cannot make good recommendations on adequate reimbursement for dialysis care. Without adequate reimbursement dialysis facilities cannot continue to improve quality of care for their patients.

Conclusion

Again, the association thanks the committee for the opportunity to present our recommendations for improving quality of care in dialysis facilities and HCFA's oversight of the ESRD program. I would like to conclude by stressing to the committee that without adequate funding of dialysis facilities, providers cannot continue to improve outcomes and reduce mortality rates, which are the true measures of quality of care for ESRD patients. The NRAA urges the members of this committee to join with Senators Frist and Conrad in support of an annual inflation update being added to Medicare's reimbursement for dialysis facilities to help achieve this goal. At this time I would be pleased to answer any questions that you might have.