Perspectives on the Future of Nonhospital-Based Arteriovenous Access

Timothy Pflederer, MD, discusses the role of CMS in dialysis access, the volume of inpatient versus outpatient dialysis access procedures, and current and future trends in reimbursement.

How influential is the Centers for Medicare & Medicaid Services (CMS) in the dialysis access procedural landscape? How would you explain the agency's role?

CMS is critical because they establish coverage and payment rates for the procedures we do in taking care of dialysis patients. Renal Physicians Association (RPA), Society of Interventional Radiology (SIR), and Society for Vascular Surgery (SVS) participate in the American Medical Association (AMA) Current Procedure Terminology (CPT) committee and Relative Value Update Committee (RUC) to establish and value codes. However, it is ultimately CMS who determines the payment rates.

Why does CMS pay for the care of end-stage kidney disease (ESKD) patients who are aged < 65 years?

All patients with ESKD were given entitlement to Medicare in the 1972 Social Security Bill because it was recognized that dialysis was life-sustaining therapy to which everyone should have access. However, at that time no one thought the disease would involve nearly as many people as it does today.

What are the available data (or your best educated estimate) as to how much of the dialysis access procedures in the United States are done on an outpatient basis?

According to Medicare claims data, < 5% of dialysis access angioplasties (36902) are done on an inpatient basis. Thrombectomy is done a bit more on an inpatient basis, but overall, the dialysis access endovascular procedures (36901-36909) are done > 90% of the time as outpatient procedures.

In what settings are these outpatient procedures predominantly done?

The hospital outpatient department (HOPD place of service 22) used to be the primary site for dialysis access procedures. However, that changed significantly over the past 10 years, and now the majority are done in the physician office-based lab (OBL place of service 11). The trend now is moving toward more procedures being done in the ambulatory surgery center (ASC place of service 24). Currently, > 50% of dialysis access angioplasty procedures (36902) are done in the ASC. The OBL and ASC make up about two-thirds of all procedures.

Do you feel there are overall quality differences at each different point of care? If so, how is this quantified or demonstrated?

Hospitals have difficulty responding to the more urgent procedure needs that dialysis patients require because of busy schedules that are mostly not related to dialysis access. A specialized nonhospital center can respond more rapidly and may have more staff and physician expertise to positively impact patient outcomes and education because of the higher volume of dialysis access cases. Additionally, these centers can do a good job of coordinating with the patient's dialysis facility—something critical to ensuring dialysis is continued in a timely fashion and patients are not unnecessarily hospitalized. There have been some studies that support these benefits

of nonhospital access centers, although to be fair, I practice in that access center environment.

What are the key trends in reimbursement relative to these three points of care over the past decade? What has changed and why?

Payment outside of the hospital has been volatile as the place of service changed over time from HOPD to office/ASC. As the majority of these procedures shifted to being paid from the physician fee schedule, the payment rate was dramatically reduced. This stabilized some as the new family of endovascular procedure codes (36901-36909) was created in 2017. Payment changes since 2017 (as well as other clinical benefits) have favored the ASC site of service.

For points of care in which reimbursement has been reduced, how have these centers survived, and what is the potential impact of future cuts?

The main strategy centers used to survive the cuts in payment for dialysis access procedures was to diversify into performing other procedures for dialysis and nondialysis patients. I don't see this as a positive development for dialysis patients, although I do understand the business realities. The benefit outpatient centers bring is the dedicated focus on the needs of the ESKD patient, and it is critical that we do not lose that focus because dialysis access complications are an important driver of the high cost of caring for these patients—and, more importantly, are a terrible burden on these patients and their families.

What do you predict for future CMS reimbursement trends for key points of care for dialysis access?

We are rapidly moving to value-based care arrangements with Medicare and commercial payers where payment will be based on overall quality and cost efficiency. That is a very positive change for patients and physicians. Fee-for-service (FFS) care provides no incentive to limit procedures or improve long-term outcomes. FFS payment is always subject to pressure to reduce the price paid for that service. The new Centers for Medicare & Medicaid Innovation's Kidney Care Choices models provide incentives for physicians to focus on the longitudinal continuum of the patient's dialysis access needs (in context with other needs) and ensure the best outcome at the lowest cost. That is clearly better for patients and if structured correctly, will allow physicians to be more fairly compensated as well. Commercial payers are also seeing the benefit of value-based arrangements and contracting with providers to assume the risk of quality and cost.

What can physicians do to help guide CMS in the future with respect to access care?

The most important thing physicians can do is join their medical society and become active in giving voice to dialysis access issues. For nephrologists, that is the RPA, which represents the practicing nephrologist and advocates on behalf of practices and patients with Congress, CMS, and local Medicare carriers. RPA is the only nephrology organization with a seat at the table at the AMA CPT and RUC where our dialysis access procedure codes are created, surveyed, and periodically revalued. The SIR and American College of Radiology represent interventional radiologists on these AMA committees and SVS represents vascular surgeons. The physician voice is most impactful through your medical society, and it is critical that everyone is involved.

If known, what has care during the pandemic taught us about points of care in dialysis access? What are some of the potentially enduring lessons of the past year?

The data have shown that there was much less disruption in patient access to necessary dialysis access procedures in locations where dialysis access care was available in outpatient access centers. Hospitals closed to "elective procedures" and did not recognize that placing and maintaining dialysis access is not elective—indeed, it is life sustaining for our patients. The best preparation for the next pandemic (God forbid) is to ensure you have an outpatient access center where you can perform procedures and/or refer patients for care. ■

Timothy Pflederer is President of the RPA, which represents practicing nephrologists and their patients throughout the United States. The RPA's mission is to empower nephrology professionals through leadership development and mentorship, regulatory and legislative advocacy, and development and promotion of best business and care delivery practices.

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