

# ***GESTIÓN DEL AV: ¿PÚBLICA O PRIVADA?***

La experiencia de USA

## **Management of AV Access: public or private?**

The American experience

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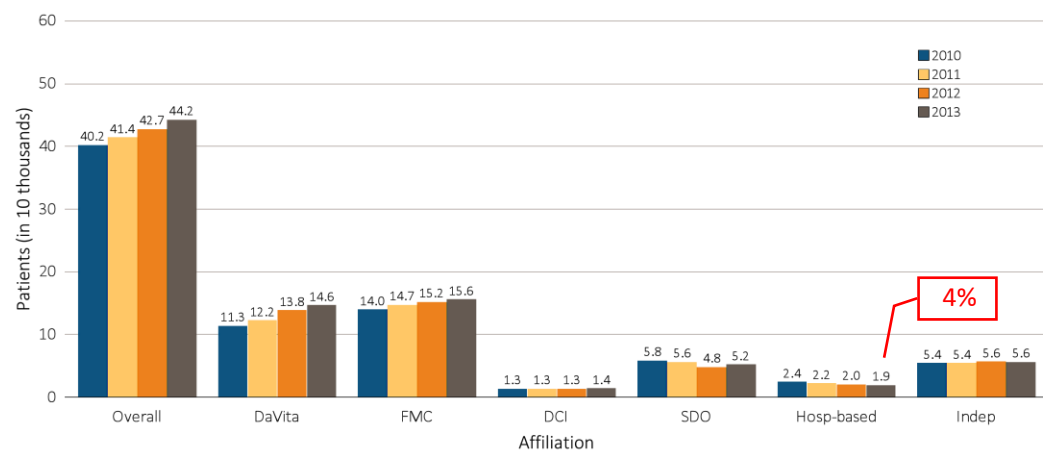
The Access Center at West Orange

West Orange, New Jersey

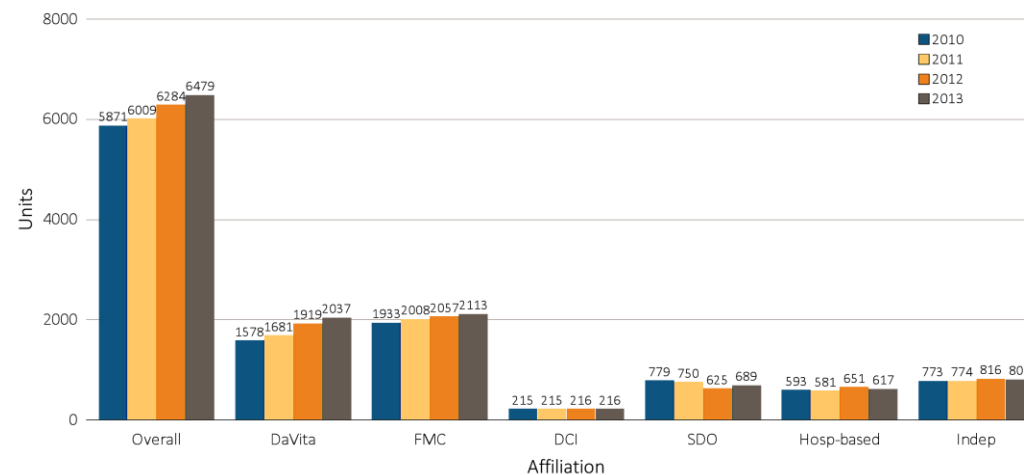
USA

# Dialysis in the United States

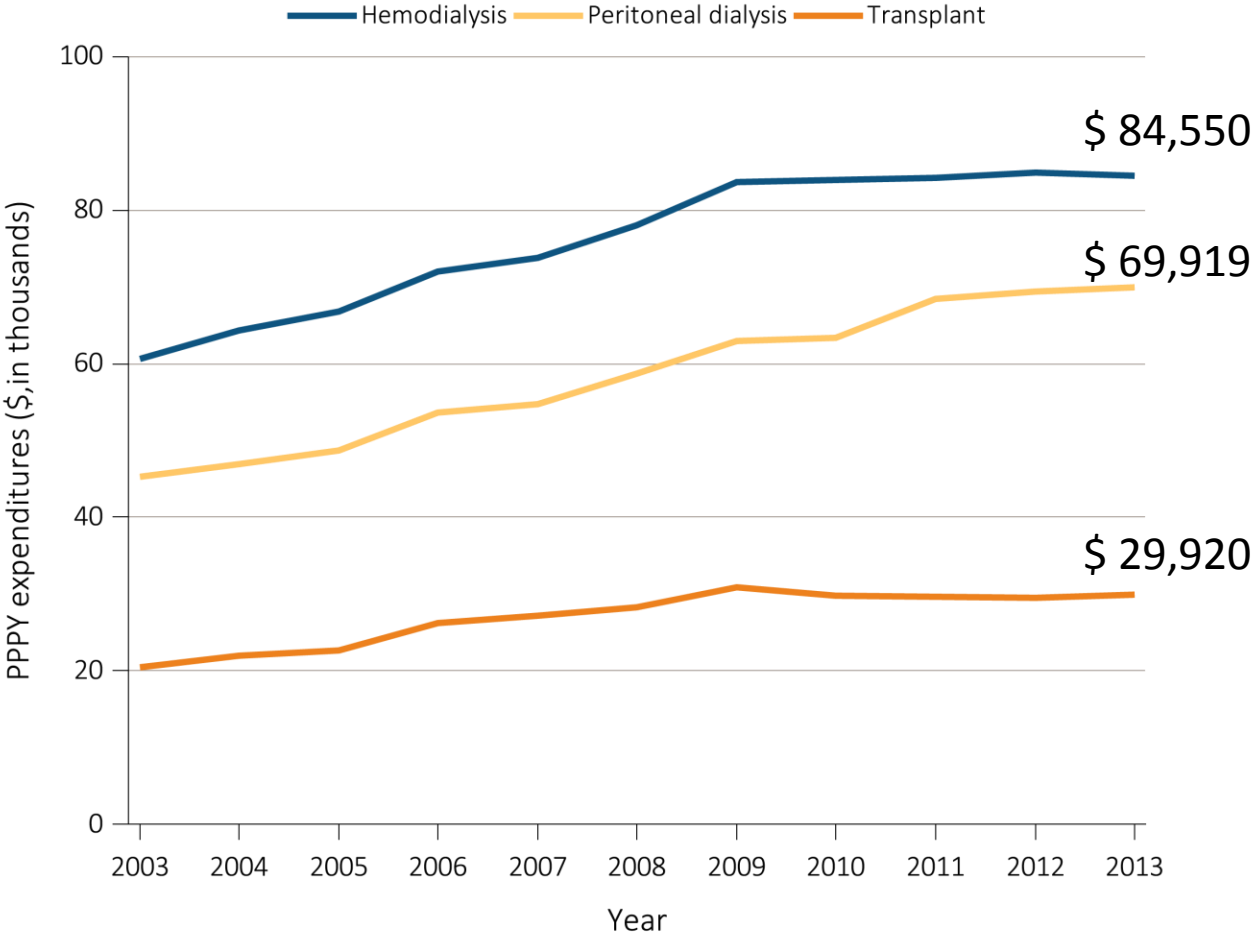
## Dialysis patient counts, 2010–2013



## Dialysis unit counts, 2010–2013



**Figure 11.7 Total Medicare ESRD expenditures per person per year, by modality**



*Data Source: Reference Table K.7,K.8,K.9. Period prevalent ESRD patients; patients with Medicare as secondary payer are excluded. Abbreviations: ESRD, end-stage renal disease.*

# **CMS PPS (prospective payment system)**

Lump sum payment/patient for up to 3 dialysis sessions/week

## **CMS demands proof of satisfactory hemodialysis**

- Adequacy of hemodialysis
  - Ability to consistently achieve satisfactory clearance
  - Proper AV access function
- CROWNWeb
  - Real-time data submission and collection
  - Required as a condition for continued reimbursement.
  - CMS standards must be met by as a condition for continued reimbursement.

# AV Access management: U.S. Public sector (hospitals)

## Advantages

- Always open
- Emergency, inpatient and outpatient services
- Backup
  - dedicated specialists treat multiple problems of varied complexity
- Operating rooms, Intensive care, cath labs, anesthesia
- Staffing, training, inventory, equipment
  - Full range of services provided

## Disadvantages

- High cost of providing services +++
- Reimbursement risks linked to PPS
  - Inpatient services = profit
  - Outpatient services = loss
- Scheduling challenges
  - sickest inpatients, emergencies first; all others wait
  - Difficult to predict case mix, complexity and throughput
- Inconvenience to outpatients
- Missed dialysis = impaired adequacy

# Access management: U.S. Private Sector

(Ambulatory surgery centers, dedicated access centers, doctors' offices)

Privately financed (Individuals, groups, companies)

Real financial risk/potential gain

Strict laws prohibiting self-referral, inducements, income splitting by referral



Same strict State, Federal standards, inspections, certification as for public sector

Receiving agreement for emergency hospital admissions

*Tight control over governance, operations, staffing, etc.*

# Advantages of private management of AV access in the U.S.

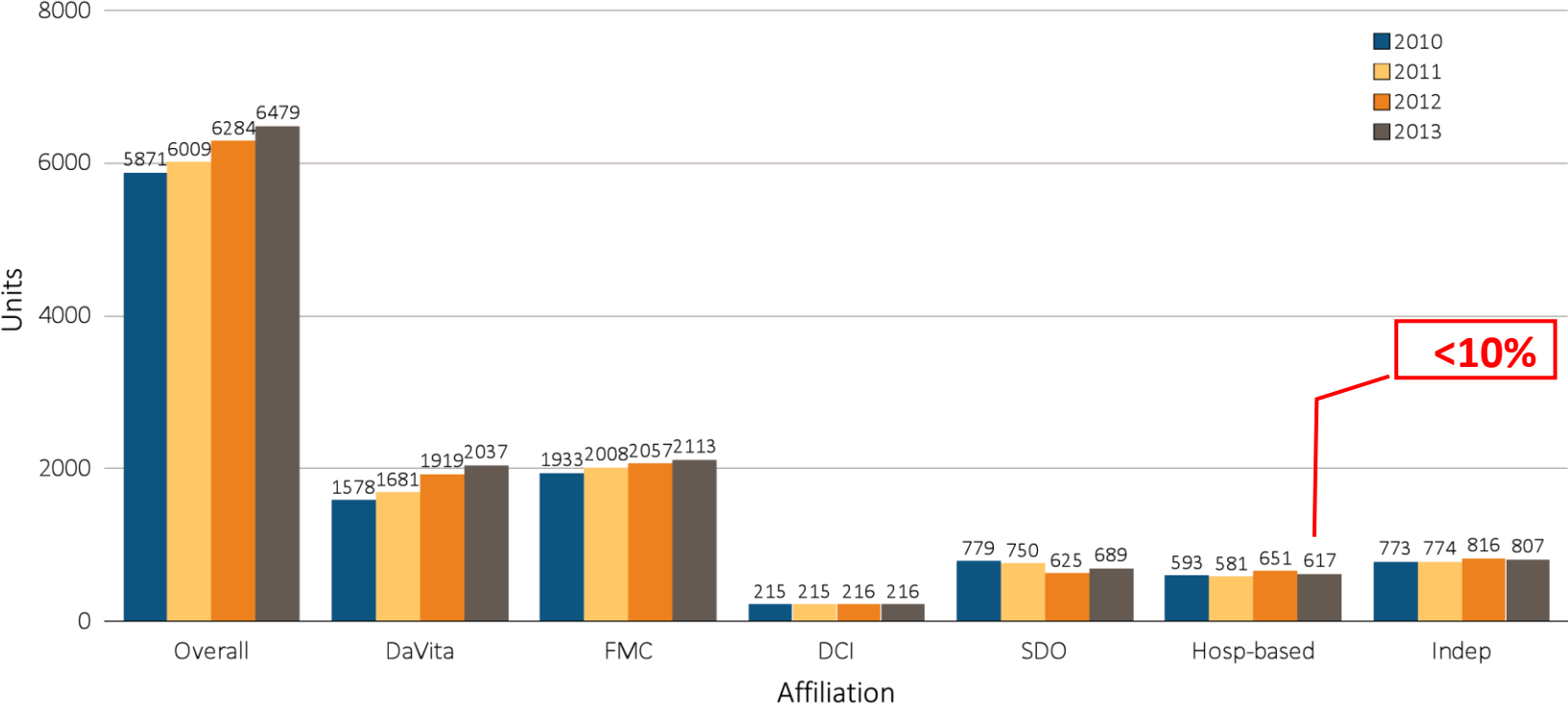
## Advantages (dedicated access center)

- Focused services, inventory, equipment, personnel
- *Maintain* proper AV access function
- Full-time anesthesia: Safety, back-up, pain management
- Rapid room turnover,  throughput
- Adherence to schedule
- Accommodate add-ons
- Lower fixed cost / case +  volume
- Improved profit potential

## Advantages (patients, MDs, dialysis centers)

- Vertical integration
  - One call to schedule
  - Transportation
  - Treatment, revision
  - Patient/family teaching ++++
  - Continuity of follow-up
- Min. disruption to daily schedules
- Help dialysis centers maintain CMS goals for adequate dialysis

**Figure 10.1 Dialysis unit counts, by unit affiliation, 2010–2013**



Data source: Special analyses, USRDS ESRD Database. Abbreviations: DCI, Dialysis Clinic, Inc.; FMC, Fresenius; Hosp-based, hospital-based dialysis centers; Indep, independent dialysis providers; SDO, small dialysis organizations.



# Conclusions

- Hospital costs > prospective reimbursement by CMS.
- Hospital-based outpatient chronic dialysis and AV access management are *unprofitable* in the U.S.
- Private outpatient AV access management can be *profitable* if:
  - well managed
  - Shares same goals as dialysis centers
  - offers prompt, valuable service to doctors, dialysis centers, patients
  - convenient, patient and family-centric
  - better outcomes than the competition
  - adequate patient volumes

