NCN | NORTH CAROLINA NEPHROLOGY, P.A.

March 20, 2018

State Health Coordinating Council
Christopher Ullrich, MD, Chairman
c/o Healthcare Planning and Certificate of Need Section
2704 Mail Service Center
Raleigh, NC 27699-2704

RE: Petition for Change to Basic Methodology by American Assess Care of NC, PLLC, Eastern Nephrology Associates, PLLC, Metrolina Nephrology Associates, PA, North Carolina Nephrology, PA, and Fresenius Vascular Care, Inc. d/b/a Azura Vascular Care.

Dear Dr. Ullrich,

North Carolina Nephrology, PA is the second largest nephrology practice in NC with 19 nephrologists, 13 advanced practice providers and 5 dedicated interventional nephrologists. We are writing to support the above-referenced petition to remove dedicated vascular access operating rooms from the operating room need methodology, or alternatively for a demonstration project to develop dedicated vascular access ORs in each health service area statewide.

North Carolina Nephrology currently has 2010 ESRD patients who must have a functioning access to receive life-sustaining dialysis. Our patients currently receive state of the art dialysis access care at the Raleigh Access Center. This center has been operational since 2008 as an office-based outpatient vascular access center and currently performs over 3000 access procedures per year.

We support the petition and the development of licensed ambulatory surgery centers with special purpose ORs for vascular access procedures outside the general OR need methodology, similar to the way hospitals can apply to develop dedicated c-section ORs today. Dialysis patients have unique and complex needs that benefit greatly from the coordinated care that their nephrologists provide in a vascular access center; hospital surgical departments and traditional ASCs are not well-suited to this population.

In 2017 CMS cut reimbursement for access procedures in an office based setting and simultaneously increased reimbursement for these same procedures in an ASC setting. Since 2017 the cost of performing dialysis access procedures in our access center became greater than Medicare (CMS) reimbursement for these procedures, and our practice cannot sustain the loss from these critical procedures indefinitely. Our interventional colleagues in other states quickly converted their outpatient access centers to ASCs to avoid closure due to this financial concern. Unless vascular access centers can be licensed as ASCs in NC, these procedures will ultimately be referred to hospitals. Unfortunately,

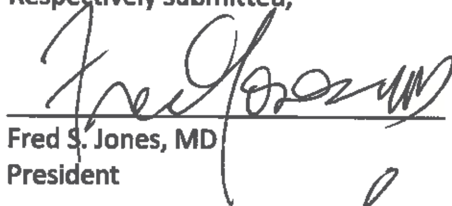
Dr. Michael Casey, Dr. Jason Eckel, Dr. William Fan, Dr. James Godwin, Dr. Karn Gupta, Dr. Jeffrey Hoggard,
Dr. So Yoon Jang, Dr. Fred Jones, Dr. Dan Koenig, Dr. Kevin Lee, Dr. Sammy Moghazi,
Dr. Michael Monahan, Dr. Michael Oliverio, Dr. Olivo, Dr. Sejan Patel, Dr. Eric Raasch, Dr. Mark Rothman,
Dr. Samsher Sonawane, Dr. Adam Stern, Dr. Phillip Timmons

hospitals do not specialize in dialysis access care and frequently cannot accommodate urgent cases as quickly as a specialized dialysis access facility. In fact, when national standards for hemodialysis access care were established, (KDOQI 1997, Fistula First Initiative 2003) it was clear that hospitals could not achieve these national care standards; patient hospitalizations for vascular access remained high and patient outcomes suffered. This situation was the driving force for the creation of outpatient dialysis access centers. The efficiency and the cost savings of these outpatient centers have been documented in the literature. Over 80% of dialysis access care in the US is now performed outside of the hospital.

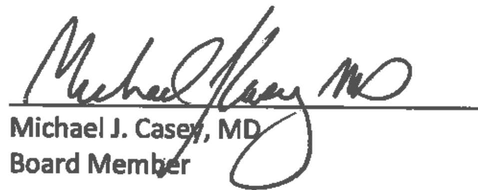
The requested change to the OR need methodology would allow ongoing timely and efficient access care by the physicians who understand these complex patients the best, their nephrologists. It would reduce the cost of care for dialysis patients by helping ensure timely interventions, preventing unnecessary hospitalizations, and by allowing dialysis access procedures to be done in a less expensive ASC setting. It would also improve coordination of care and result in better patient outcomes for dialysis patients compared with providing this care in hospitals. In addition, because most dialysis access procedures have been provided in physician offices in the past, allowing the petition will not adversely affect other ASCs or hospitals.

In conclusion, North Carolina Nephrology reiterates that the unique characteristics of dialysis patients justify a change to the SMFP that would exclude dedicated vascular access ORs from the general OR need methodology such that they could be developed without a prospective need determination. At a minimum, a demonstration project should be approved to allow development of dedicated vascular access ORs in ASCs in each Health Service Area statewide, to evaluate the effectiveness of this specialized care model.

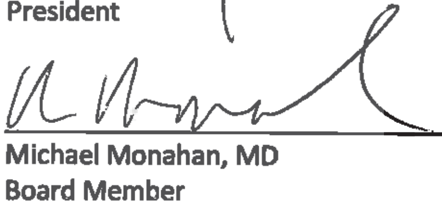
Respectively submitted,



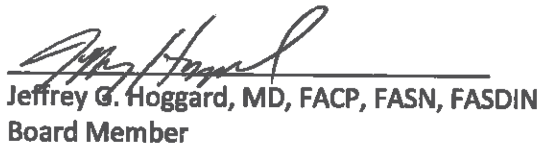
Fred S. Jones, MD
President



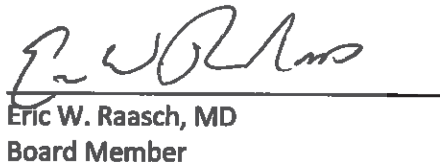
Michael J. Casey, MD
Board Member



Michael Monahan, MD
Board Member



Jeffrey G. Hoggard, MD, FACP, FASN, FASDIN
Board Member



Eric W. Raasch, MD
Board Member

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