Join RPA for Capitol Hill Day in May and the PAL Annual Forum in June

With spring upon us and summer not far behind, it is time for RPA’s mid-year policy apparatus to crank up its work. This activity will begin on May 13, 2022, with a once-again virtual version of RPA Capitol Hill Day. Given that you are receiving this issue of RPA News on or around May 1, registration is well underway, but there is still time to join us. Please take the opportunity to lobby for your future success by registering at www.renalmd.org.

While the virtual format does not provide the magic of walking the Senate and House office buildings, many participants greatly prefer the convenience afforded by virtual visits in the last two years. Hill Day attendees will have access to an online platform through RPA’s longtime Hill Day vendor, where you can log in on your laptop/desktop to access your schedule. You just need your email to log in. The conference line and access code will be displayed in the Location field for each meeting. Additionally, the platform allows for relevant information regarding the meeting: Time, Office of, Meeting With, Additional Attendees on the call, Team Lead, Co-sponsored bills and Talking Points that provide the material you may want to have in front of you during the call. A week or so before Hill Day, material you may want to have in front of you during the call. A week or so before Hill Day,

Meet the New RPA Board Members

Khalil Rahman, MD, MBA, is President of Nephrology Associates of Lexington, a seven nephrologist, three advanced practice providers, nephrology practice in Lexington, KY. Dr. Rahman was inspired to become a physician by his father, a family physician in Pakistan whose care and respect for his patients were a foundational influence. However, before becoming a nephrologist, Dr. Rahman spent eight years as a professional field hockey player (Pakistan’s National game), starting at the age of 16 and continuing even as he started medical school. Dr. Rahman was drawn to nephrology as it allowed for long-term relationships with patients and complex problem solving to provide the best possible care. He views nephrology as caring for the patient as a whole, not just their kidneys. Dr. Rahman has long been active in the Lexington Medical Society and Kentucky Medical Society, advocating for healthcare providers and high-quality patient care on the state and local levels. After attending an RPA meeting in Washington, DC, he saw the opportunities to advocate at the national level and became active in the Healthcare Payment Committee.

As a Board member, Dr. Rahman hopes to attract new members by showing them the value of RPA, including the resources and benefits we provide to their practices. He also hopes to continue to grow his understanding of the legislative and regulatory sphere and advocate for providers and issues surrounding patient care, including telehealth, medication access, and the unique challenges of providing care in rural areas.

In his free time, Dr. Rahman enjoys traveling with his family, cycling, and tending to his farm with bees, chickens, goats, and sheep. He is also an avid college basketball fan and attends games whenever possible.

From Capitol Hill

The Fragile, Fleeting Beauty of...Congress?

By Robert Blaser, RPA Director of Public Policy

For those of you who have never visited Washington, it is a truly beautiful city, especially in springtime when the cherry blossoms are in bloom. And while the flowers are breathtaking, their lifespan is like many things largely dependent on the weather, as peak bloom usually lasts about a week or two. Still, if there is either a deep cold snap (as happened this year) or a high wind/rain event, the blossoms can be stunning one day and gone the next.

While the notion of fragile, fleeting beauty in nature is not revelatory, it can exist in other realms, such as human behavior. Examples here include jelling squads in sports (St. Peter’s in March Madness, anyone?), teams of researchers developing groundbreaking biomedical advancements, groups of work professionals coming together for a big event (I was going to refer to RPA staff and the great Annual Meeting in March, but my RPA colleagues’ effectiveness in making activities like that happen is neither fragile nor fleeting), and yes, Congress (whose effectiveness and beauty is almost always both fragile and fleeting).

Typifying the glimmers of hope amongst the Congressional dread was the fiscal year (FY) 2022 appropriation process. Recall that when we last left the federal government funding process, it was occurring through a series of continuing resolutions (CRs) that had the expedient intent of keeping the government open, but which also extended a federal budget that reflected the priorities of the previous Administration and not that of President Biden’s team. Support for passage came from the desire to provide aid to Ukraine as part of the full year funding package, and this would lead legislators across the political spectrum to vote in favor. Concerns centered

Remote Patient Monitoring

Continued on page 3

Continued on page 4

Continued on page 5
While you are reading this in May, I wrote it soon after returning from our annual meeting in Dallas. The COVID variants cooperated, allowing us to have one of the largest RPA meetings ever. More than 665 attendees joined us in Dallas, with approximately 70 more joining us via live stream.

I had a great time at the meeting, and it was wonderful to see so many new and familiar faces in person instead of on screen. I would like to thank Drs. Gary Singer, Chair, Brendan Bowman, Vice Chair, and the entire Education Committee for an excellent program, as well as our incredible Director of Meetings, Desiree Bryant. Ours is a unique gathering in that practice leaders, nephrology practitioners, and administrators learn together how to structure care for optimal clinical and business outcomes. The annual meeting offered a wide range of topics supporting our vision of advocating for excellence in nephrology practice. Check out the story on page 8 for highlights of the meeting.

The theme of the 2022 meeting was Facing the Future of Kidney Care. This topic was certainly visionary as alternative risk-bearing payment models rapidly expanded from Medicare, Medicaid Advantage, and Commercial payers, and value-based care companies desiring to partner with nephrologists in patient care exploded onto the scene. The meeting title was also timely for our RPA organization. As you likely know, RPA’s longtime Executive Director Dale Singer retired in February to focus on her health. Dale is a unique leader who empathized with the struggles of kidney patients, worked tenaciously alongside nephrologists towards optimal care, advocated for nephrology practice success, and mentored a staff of highly skilled professionals. While we are missing her, we are looking to the future expectantly as we undertake a search for a new Executive Director. The goal is to have our new leader in place by January 2023.

RPA’s goals for this time of great transition aren’t just limited to organizational leadership. We are calling upon all nephrologists in the United States to engage with us in our mission, lending their experience and expertise to equip practices for success, and effectively advocating for our patients during a time of tumultuous change. We need everyone to do this well, and that is why we have a strong membership focus for the remainder of 2022. We hope many more practices will join our single invoice practice (SIP) option so that all their providers can join our work and exercise their voice in advocacy. We hope you will challenge colleagues to join RPA this year.

It is the community of nephrology providers—young and older, employed and private practice physicians, advanced practitioners, and administrators—working together who will profoundly transform the care of kidney patients. We can reduce disparities, increase access to care, and improve the quality of life for patients and their families. I began practice in 1993 and cannot remember any time with the opportunity to make a difference like right now.

If we get this right, improvements for patients and practices will be revolutionary. If nephrologists lead and leverage RPA, we will get this right.

Are you ready for this exciting journey? Are you ready to engage? Email Interim Executive Director Amy Beckrich (abeckrich@renalmd.org) asking to join any of our committees. Choose the one that fits your expertise or interest, such as Education (plans the RPA Annual Meeting and other offerings); Government Affairs (works to strengthen the public/private policy agenda for RPA); Quality, Safety, and Accountability (works to develop programs, measures, and tools to promote accountability, quality, and safety in all practice settings); Clinical Practice (focuses on all aspects of nephrology practice, including the value of nephrologist-directed kidney care); Health Care Payment (works on Medicare and private payers issues and maintains liaison with the AMA RUC and CPT advisory panels); and Practice Managers (plan programs of particular interest to practice administrators and oversee development and analysis of benchmarking survey). Additionally, please join us for RPA’s Virtual Capitol Hill Day on May 13 to be guided in effectively advocating with your legislators for RPA’s legislative priorities. And join us for the next in-person meeting—the Policy Advocacy Leadership (PAL) Forum—on June 25-26 in Washington, DC. There’s no cost to register for Capitol Hill Day or the PAL program. Additional details are provided on page 1.

Finally, make sure you join us at the next annual meeting in New Orleans from March 30 – April 2, 2023!
In Memoriam: Christopher R. Blagg, MD

The nephrology community lost one of its pioneers on March 31, 2022, when Christopher Blagg, MD, passed away. Dr. Blagg was instrumental in the founding of RPA, serving as our second President from 1976-1977. He was a charter member and constant presence at what are now the RPA Government Affairs and Health Care Payment Committees. For over four decades, Dr. Blagg's professional home was Northwest Kidney Center (NKC) in Seattle WA, the birthplace of modern dialysis, where he served as the organization's Executive Director for 27 years. One of the giants of American nephrology, Dr. Blagg was among the first nephrologists to develop a home hemodialysis program at NKC, which served as a model for patient-centered home dialysis, and for decades he championed patient-centered care for CKD patient who required life-sustaining dialysis treatment. The Christopher Blagg lectureship he supported via RPA and which is held at the annual ASN meeting focused on the need for legislative and regulatory support for patients with ESRD. He was truly one of the patient-champions and professional role models for nephrologists, nurses and healthcare personnel caring for dialysis patients. Dr. Blagg was a kind and humble individual who combined those qualities with fierce and passionate advocacy on behalf of our kidney patients, home dialysis, and the importance of leadership from nephrologists in providing kidney care. Rest in peace, Dr. Blagg.
Meet RPA New Board Members
from page 1

Evan Norfolk, MD, is a nephrologist at Geisinger, an integrated health services organization in Danville, PA. Dr. Norfolk joined Geisinger in 2004 and has been the director of nephrology since 2014. Dr. Norfolk always wanted to help people through medicine. During his residency, he realized that nephrology provided him the opportunity to develop long-term relationships with his patients, and he was inspired to solve the complex puzzles that are a part of nephrology care. His interest in improving the quality of healthcare led to him become certified in clinical informatics.

Dr. Norfolk was introduced to RPA by a colleague and was drawn to the advocacy, coding, and policy education that RPA provided, as these are not taught in training. He values the unique offerings of RPA, saying, “There is no other organization like RPA that provides a voice for nephrologists out in the real world.” As a Board member, Dr. Norfolk hopes to give back to the nephrology community as well as help RPA grow and explore new directions to address unmet needs.

In his free time, Dr. Norfolk enjoys spending time with his family and exploring the outdoors.

Charlotte Dixon is the executive director of Hawaii Kidney Specialists in Honolulu, HI. Originally from Texas, Ms. Dixon has spent her entire career in healthcare, starting as a biller in a radiology office at age 19. She has worked with several specialties, including family practice, ophthalmology, and cardiology. She has also honed her IT skills in these roles, serving not just as an administrator but also as an IT coordinator. Ms. Dixon notes that while office management is fairly similar across specialties, she enjoys nephrology’s unique challenges, including joint ventures and dialysis units that require her to wear many hats.

Ms. Dixon joined RPA after her first week working in a nephrology practice, at the suggestion of one of the physicians and the office manager, noting that RPA “has been an invaluable resource.” As a Board member, Ms. Dixon hopes to make a difference for nephrology providers so they in turn can make a difference for their patients. She looks forward to advocating to remove administrative burdens that take away from time that providers can spend on patient care.

Since moving to Hawaii in September 2020, Ms. Dixon has taken up snorkeling and spending time in the water. She’s also enjoying exploring the food scene and looks forward to resuming traveling.

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on the Democratic majority’s desire to support social safety net programs and Pentagon funding, a complicating factor for progressive House Democrats. Additionally at the 11th hour, progressive Democrats also rebelled over the package of additional funding for COVID-19 concerns, and those provisions had to be pulled from the bill. This was much to the ire of House Speaker Nancy Pelosi (D-CA), who wanted the COVID funds packaged with the Ukraine aid to facilitate its progress. However, in fairness to the Democratic progressives, the COVID tranche was somewhat sloppily put together with questionable offsets (such as clawing back unspent funds from the states, angering many state governors). However, their defiance of the President and Ms. Pelosi had some legitimacy.

So, where was the glimmer of hope in this? The fact that once the House passed their COVID-less version of the bill and another CR with the reasoning that there was no way that the House appropriations bill would pass the Senate before the end of the previous CR in two days, it did pass (if that all makes sense). This was not entirely shocking, as the lead Republican appropriators (Senator Richard Shelby—R-NC, and Rep. Kay Granger—R-TX) plus Senate Minority Leader Mitch McConnell (R-KY) had all expressed their support for the bill. However, any legislation passing the Senate in two days is noteworthy and, well, beautiful (in a legislative progress sense). Another light in the tunnel emanated from funding for kidney health priorities, such as: (1) KidneyX received $5 million, the same amount as in the previous budget but for which the kidney community is still grateful; (2) NIDDK (the NIH kidney institute) received $2.2 billion, a 3.37% increase, which is in line with other NIH institutes; (3) the CDC received $3.5 million for kidney disease surveillance and awareness; and (4) the National Living Donor Assistance Center (NLDAC) received $7 million.

On other issues, the conclusion of the current public health emergency (PHE) and what this means for the extension of telehealth flexibilities is consuming a lot of the health policy oxygen in DC. On the PHE, there are a multitude of questions that must be resolved before it concludes.

An incomplete list of these includes: (1) whether the telehealth originating site and geographic restrictions are eliminated once and for all; (2) will federal waivers on interstate use of telehealth be removed (these are already being scaled back at the state level in some geographies); (3) will ‘social’ policies such as full federal funding of free school lunches continue; (4) will the active status and current Medicare payment levels of the telephone-only CPT codes (99441-99443) be maintained; (5) what will happen to waivers allowing the expanded scope of practice for some Medicare providers; and (6) what will happen to the requirement for insurers to provide free COVID tests. There are obviously thorny political concerns among the questions posed above before the PHE is lifted.

Notably, a 151-day (five-month) extension of the current telehealth policies from the conclusion of the PHE was included in the FY 2022 funding package discussed earlier. However, the big question now is when does that clock start ticking? At press time, the PHE was set in place until April 15, and virtually all observers in Washington think it will be extended at least once more until about July 15. Some DC policy analysts believe there is no way it will be extended beyond then. At the same time, other players, such as some organized medicine groups, are calling for it to be extended until the end of 2023 to give Congress sufficient time to develop a thoughtful plan for moving forward. In any event, the process for concluding the PHE will be expensive, complicated, and will require close coordination between the House, the Senate, and the Administration. So, it might be a while.

Another issue on which there may be a ray of light is Prior Authorization (PA) legislation. Last year saw the introduction of the Improving Seniors’ Timely Access to Care Act of 2021 (H.R. 3173/S. 3018) that would establish requirements for the use of PA under Medicare Advantage plans and create a more streamlined and transparent process that is subject to enhanced oversight. Among other specific provisions, the bill would: (1) establish an electronic prior authorization process; (2) require HHS to establish a process for “real-time decisions” for items and services that are routinely approved; (3) require Medicare Advantage plans to report to CMS on the extent of their use of prior authorization and the rate of approvals or denials; and (4) encourage plans to adopt prior authorization programs that adhere to evidence-based medical guidelines in consultation with physicians. The legislation currently enjoys an abundance of bipartisan support in both chambers (275 co-sponsors in the House, 22 in the Senate), and Hill staff have expressed to RPA that they believe this legislation has a strong possibility of enactment in 2022.

In late February, positive news for physicians emerged when a Texas judge ruled in favor of the organized medicine position on independent dispute resolution (IDR) set forth in the No Surprises Act rulemaking. At issue was using a health plan's Qualifying Payment Amount (QPA) in the IDR process. The judge ruled that in its rulemaking, CMS gave excessive weight to the QPA, stating that: “The rule . . . places its thumb on the scale for the QPA, requiring arbitrators to presume the correctness of the QPA and then imposing a heightened burden on the remaining statutory factors to overcome that presumption . . . If Congress had wanted to restrict arbitrators’ discretion and limit how they could consider the other factors, it would have said so—especially here, where Congress described the arbitration process in meticulous detail.”

Subsequently on February 28, CMS posted a memorandum indicating that they are, in essence, withdrawing any guidance about the provisions of the rule affected by the judge’s decision, and some are interpreting this as the Agency conceding that they would likely lose in court on this point. As noted, this is a victory for organized medicine as when the rule was finalized last year AMA and the House of Medicine objected that the rule ignored Congressional intent in favor of health plans and insurers. From the Hill perspective, this conflict reprises a battle between the House Ways and Means (W&M) Committee on one side and the Senate Finance Committee (SFC) and House Energy and Commerce (E&C) Committee on the other, where W&M took the side of physicians and organized medicine and SFC and E&C were proponents of the health plans. To this point, when the rule came out last year, W&M Chair Richard Neal (D-MA) and many other legislators strenuously objected to the proposed No Surprises policies, saying it was diametrically opposed to Congressional intent. However, SFC Chair Patty Murray (D-WA) and E&C Chair Frank Pallone (D-NJ) lauded the rulemaking and said it was exactly what they intended. Much of the angst among Congressman Neal, his allied legislators on this issue, and organized medicine is the perception that when the legislation was passed, it reflected a physician-centric stance, and the rulemaking seemed to implement the opposite position. It now looks like the judge agreed with Rep. Neal and organized medicine. More to come.

On the overarching issue of Medicare physician fee schedule/Part B reimbursement, the degree to which Congress acknowledges that something needs to be done is encouraging. Organized medicine is undertaking a considerable effort to get Congress to look at the fundamentals of Medicare payment, and while various spokes of the problem exist, primarily the issue goes back to the use of budget neutrality in the fee schedule. The AMA and others are seeking innovative ways to address spending ceilings in Part B that do not require strict budget neutrality. Beyond that, the sequestration/PAYGO
cuts are still on the books for this year and 2023, and the 5% MACRA bonus for advanced alternate payment model (AAPM) participation is slated to sunset after PY 2024. The AMA is trying to eliminate the ‘cuts on autopilot’ orientation of all these spending ceiling devices in the fee schedule. On the specific point of the AAPM bonus, the good news is that multiple legislative initiatives would extend the bonus for several years, so it’s a strong possibility that this change would be included in any late-year Medicare package. Broadly, few analysts think that significant Medicare physician payment cuts will happen in 2023, but how much relief is provided and how we get there remains to be seen.

Regarding RPA’s 2022 legislative priorities, the living organ donation bill (The Living Donor Protection Act—S.377/H.R. 1255) is up to 36 co-sponsors in the Senate and 108 in the House, and our favored telehealth legislation (the CONNECT for Health Act of 2021—S.1512/H.R. 2903) is at still at 61 Senate co-sponsors and up to 128 House co-sponsors. Thus, both bills gained notable Congressional support in the first quarter of 2022. As for community, the CKD bill (the Chronic Kidney Disease Improvement in Research & Treatment Act—S.1971/H.R. 4065), is still at the two original sponsors in the Senate and gained one co-sponsor in the House, bringing the total to eight. RPA’s newest legislative priority, the Improving Access to Home Dialysis Act (H.R. 5426), is still without a Senate companion bill but now has 16 House co-sponsors.

So, as confounding and aggravating as Congress can be at times (well, much/most/just about all the time), there is progress on some issues that may result in fragile, fleeting legislative beauty. And in other cherry blossom-related news, on March 28, the NBA’s Washington Wizards and the Washington Nationals of major league baseball unveiled cherry blossom-themed uniforms, in keeping with the current alternate uniform movement in sports. These days you must find beauty and joy wherever you can. Have a great spring.

We appreciate and value your participation in the 2022 RPA Nephrology Practice Business Benchmarking Survey.

The results will be ready this summer 2022!
RPA Recognition Awards

RPA congratulates the winners of the 2022 Recognition Awards. We appreciate all you do for kidney patient care.

Dr. Pflederer congratulated RPA 2022 Distinguished Nephrologist Dr. Rebecca Schmidt.

Dr. Pflederer congratulated Mr. Shaun Edelstein of Balboa on the 2022 Distinguished Practice Administrator Award.

North Carolina Nephrology, P.A. in Raleigh, NC, received the 2022 RPA Exemplary Practice Award.

The RPA corporate patrons program is designed to augment the alliance between stakeholder industries and the RPA, since corporate members of the nephrology community play an important role in optimizing patient outcomes. Gifts from corporate patrons are for scientific or educational purposes. During the year RPA leaders meet with representatives from corporate patrons participating companies to discuss areas of mutual concern and interest. This informal dialogue benefits industry and the association. Potential donors should contact the RPA office to obtain additional information. Links to all of our corporate patrons’ sites may be found at www.renalmd.org.

RPA is pleased to acknowledge the support provided by all of our corporate patrons in this issue of RPA News.

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For the first time since 2019, nephrologists, practice administrators, advance practice providers, and more gathered in person for the RPA Annual Meeting, and the excitement was palpable. Convening in Dallas on March 24-27, the conference set records for attendance. The meeting kicked off with sold-out pre-conference workshops on the Fundamentals of Nephrology Coding and Billing and the Medical Director Workshop, planned in conjunction with the National Forum of ESRD Networks. The Medical Director Workshop included a focus on the current responsibilities of the Medical Director, the voice of patients, and the structures and tools that optimize the opportunity for success of the outpatient and inpatient Medical Director. The RPA Annual Meeting itself kicked off with a lively welcome reception on March 24, with sessions beginning the following morning.

In his conference-opening year in review, RPA President Timothy Pflederer highlighted RPA’s achievements over the past year and provided a touching tribute to former RPA Executive Director, Dale Singer, who retired in February after 26 years with RPA. Ms. Singer made a surprise appearance via video to greet the conference attendees and provide some words of wisdom and appreciation for her tenure at RPA. This year’s Louis Diamond Lecture featured J. Corey Feist, JD, MBA, co-founder of the Dr. Lorna Breen Heroes’ Foundation, whose mission is to reduce burnout of health care professionals and safeguard their well-being and job satisfaction. Mr. Feist shared the story of his late sister-in-law, Dr. Lorna Breen, and highlighted the need to address and remove the barriers to mental health for healthcare providers. Mr. Feist was proud to announce that President Biden signed the Dr. Lorna Breen Health Care Provider Protection Act into law on March 18. The comprehensive legislation allocates specific funds towards grants for training health profession students, residents, or health care professionals in evidence-informed strategies to reduce and prevent suicide, burnout, mental health conditions, and substance use disorders.

The RPA meeting was packed with content, perhaps none timelier than the panel discussions and sessions focused on value-based care in kidney disease. Early in the meeting Tom Duvall from the Centers for Medicare and Medicaid Innovation (CMMI) provided an update on the status of the mandatory and voluntary kidney payment models. This was followed later in the meeting by a lively panel discussion with leading value-based care companies, a value-based care 101 discussion aimed at early career nephrologists, and a ‘lessons learned’ presentation from a highly successful kidney VBC organization, among others. Meeting sessions also provided insights into RPA’s decades-long representation of the nephrology subspecialty at the CPT and RUC tables and the RPA Research Project on the Assessment of Mineral Bone Disease in Chronic Kidney Disease Patients as well as other clinical research related to MBD. Additional sessions focused on COVID and kidney disease.

During the last day of the meeting, clinical sessions focused on genetics, applied machine learning, CKD risk equations, and a literature review. Meanwhile, the concurrent business management education pathway examined medical liability risk management, 2022 billing changes, and an open discussion on hiring and retaining employees.

Additionally, Dr. Pflederer presented the 2022 Distinguished Nephrology Service Award to Dr. Rebecca Schmidt, the 2022 Exemplary Practice Award to North Carolina Nephrology, and the 2022 RPA Distinguished Practice Administrator Award to Shaun Edelstein, MSc, of Balboa. He also recognized outgoing RPA Board members, Dr. Terry Ketchersid and Ms. Carole Ann Norman.

The RPA Annual Meeting sessions and the Fundamentals of Nephrology Coding and Billing and Medical Director Workshop are available on RPA’s eLearning platform. Visit www.renalmd.org to learn more.

Dr. Pflederer thanked outgoing Board member Ms. Carole Ann Norman for her service to the Board.

Dr. Pflederer thanked outgoing Board member Dr. Terry Ketchersid for his service to the Board.
Drs. Eleanor Lederer and Adam Weinstein provide insights into CKD MBD.

The Medical Director Workshop included patient and provider perspectives.

AAKP President Richard Knight addresses RPA Annual Meeting attendees.

J. Corey Feist, JD, MBA, co-founder of the Dr. Lorna Breen Heroes' Foundation, delivers the Louis Diamond Lecture.

Dr. S. Sudha Mannemuddhu addresses the transition from pediatric to adult nephrology care.

Drs. Eleanor Lederer and Adam Weinstein provide insights into CKD MBD.
RPA would like to thank all our exhibitors and supporters.

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The association expresses its gratitude to the Education Committee for its efforts planning an outstanding 2022 Annual Meeting Program

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As much of the world knows, the mid-term elections of the U.S. Election cycle will occur on November 8, 2022, meaning that the entire House of Representatives and about a third of the Senate seats will be on the ballot. Consequently, all the affected campaigns seek support for their candidates, and the RPA PAC is fielding dozens of requests daily seeking contributions.

With regard to how this will play out for RPA’s 2022 legislative priorities (pertaining to living organ donation, telehealth, the CKD community omnibus bill, and staff-assisted home dialysis), the issues most primed for advancement are the living organ donor bill and telehealth legislation. The living organ donation bill (the Living Donor Protection Act, S-377/H.R. 1255) is up to 34 co-sponsors in the Senate and 108 in the House. These are solid numbers that might compel policymakers to include this if a broader Medicare legislative package is enacted later this year (almost certainly after the elections if it is to occur). The status of telehealth depends on the duration of the current public health emergency (PHE). There is significant support for ending the PHE, but unwinding it will be exceptionally complex, and the issue has become more political as time has gone on.

As has been the case since the onset of the pandemic, RPA PAC activity has been relatively limited in 2022. RPA PAC participated February 1st Zoom event with Senator Ron Wyden (D-OR), Chair of the Senate Finance Committee, to discuss the cuts to office-based surgical procedures in the Medicare Fee Schedule stemming from the use of updated inputs in clinical labor pricing. House events included interactions with Reps. Fred Upton (R-MI, member of the House Energy and Commerce Health Subcommittee, and former full committee chair) Debbie Dingell (D-MI, also a member of the E&C health subcommittee), Suzan DelBene (D-WA, chair of the Congressional Kidney Caucus), David McKinley (R-WV, another E&C healthy subcommittee member and original co-sponsor of the Dr. Lorna Breen Health Care Provider Protection Act), and Jaime Herrera Beutler (R-WA, a longtime kidney care advocate). Planned events to date include those for Senators Catherine Cortez Masto (D-NV) and Tim Scott (R-SC) and Reps. Kim Schrier, M.D. (D-WA) and Vern Buchanan (R-FL, and current Ranking Member of the House Ways and Means Committee; he will likely ascend to committee Chair if the Republicans regain control of the House).

While all those events were important and productive, the unquestioned highlight of the period was the RPA PAC reception held as part of the 2022 RPA Annual Meeting on March 25 in Dallas. Rep. Colin Allred (D-TX), who represents Texas’ 32nd congressional district just outside of Dallas, was our guest at the PAC reception. Congressman Allred is a member of the Congressional Diabetes Caucus (he was urged to join the Congressional Kidney Caucus at the reception) and was also a co-sponsor of the Lorna Breen Health Care Provider Act. His remarks reflected compassion and support for the nation’s physician workforce while also being humorous. He noted that Congress needs to do all it can to sustain doctors and other health care providers through means such as COVID-based legislation and the Provider Relief Act. The humor came from his response when he saw an attendee leave the room to take a phone call. A former NFL linebacker (Rep. Allred played for the Tennessee Titans from 2007-2020), he stated that “I don’t say this often, but I did play linebacker in the NFL, I could catch you if I wanted to,” to roaring laughter in the room.

The common thread among RPA PAC activities is that we purposefully choose them to help promote the interests of nephrology. Examples include the fact that Senator Wyden wants to help address the cuts in vascular access payment. Rep. Dingell has been an angel on that and many other physician issues during her time in Congress. Reps. DelBene and Herrera Beutler have a specific interest in kidney issues, by virtue of their participation in the Kidney Caucus and for Ms. Herrera Beutler, as the mother of a pediatric kidney patient who received a miraculous kidney transplant. Congressman McKinley has been a longtime friend to the kidney community, and former RPA President Rebecca Schmidt is well known to his staff. Rep. Buchanan also has substantial previous engagement with kidney care providers and will be in a great position to assist with nephrology’s priorities should he u become chair of the Ways and Means Committee.

When Congress determines issues of critical importance affecting nephrology practice, conversations facilitated by the RPA PAC provide the nuanced perspective of nephrology practitioners that often result in positive outcomes for our specialty. If you have already supported the PAC in this Congressional cycle, THANK YOU! If not, please contribute to the RPA PAC at https://www.renalmd.org/page/PAC to generously support these efforts or send a personal check payable to RPA PAC to the RPA office, 1700 Rockville Pike, Suite 320, Rockville, MD 20852. Thank you in advance.

RPA PAC is a separate, segregated fund established by RPA. Voluntary contributions by individuals to RPA PAC will be used to support candidates for public office regardless of political affiliation who demonstrate their belief in the principles to which the profession of nephrology is dedicated. Contributions from corporations and associations as well as medical practices are prohibited by federal law and cannot be accepted. Contributions to the RPA PAC are not deductible as charitable contributions for federal income tax purposes.
I am writing this column at the end of March, one week after the first in-person RPA annual meeting in three years. It shook me to the core to see my nephrology colleagues from all over the country in person instead of virtually. During my interactions with the other early-career physicians, I realized that I will shortly transition from an early to mid-career physician (I turn 41 next month, and this is my 10th year in practice out of fellowship).

Here are some of my reflections from my first 10 years in practice.

**Learn From Your Mistakes**

In my first year of practice, one of my patients was a young woman with crescentic lupus nephritis. She was one of the first patients with lupus nephritis that I was going to manage independently since completing my fellowship. I selected intravenous cyclophosphamide for treatment. She developed fevers during one of the first several cyclophosphamide infusions. She was subsequently diagnosed with isoniazid-resistant tuberculosis with associated meningitis. She became very ill during the treatment for the tuberculosis and thankfully survived. I subsequently treated the lupus nephritis with other agents, and she’s more stable now off all immunosuppressant agents. In preparation for the cyclophosphamide treatment, I didn’t appreciate the infectious risk in treatment (I didn’t experience these issues during my fellowship). I now appreciate that risk with treatments such as cyclophosphamide and am careful to screen patients for tuberculosis and hepatitis and to make sure they are appropriately vaccinated prior to treatment.

Every nephrologist more than a few years into practice that I’ve told that story to inevitably will tell me a story about some mistake in diagnosis or management that they’ve also made. My now-retired partner used to joke that he didn’t necessarily know more than me, but he’s simply made more mistakes and learned from them. It’s not possible to cover every aspect of nephrology during a two or three-year fellowship, so you should be prepared for the inevitable errors that will occur over time. What’s important is that you learn from those mistakes and be honest with patients about them and about your limitations.

**Expect Change and Adapt**

The last several years have taught us all some lessons about change. I’ve been through several personal and professional changes over the first ten years out of fellowship. Indeed, the most dramatic has been living through a worldwide viral pandemic over the last several years. I doubt anyone could have predicted that this would trigger a rapid adoption of telemedicine (which will probably become a permanent fixture in our practice from now on). I’ve been an active member of the RPA since my fellowship and the organization has been steadfast in its mission to keep nephrology professionals current on the changes in our specialty so we can adapt our practices to stay current. Other organizations certainly are better suited to keep us current in the management of our patients, but the RPA does the best job of keeping us current in the practice of nephrology.

**Align Incentives with Your Partners**

As nephrologists, we work with several different partners — hospitals, dialysis organizations, pharmaceutical companies, and professional organizations. I find some physicians focusing excessively on the negative interactions with these entities. I find it best to focus on how our incentives align with them so we can work as effective partners. Hospitals are graded on patient satisfaction — our interactions with patients help shape the satisfaction survey responses. Patients with good interactions with their care team are more likely to provide a positive response to the survey. Hospitals are also interested in reducing readmissions — scheduling our patients for transitional care management visits is proven to reduce readmission risk. Dialysis organizations are interested in maximizing the number of treatments at their clinics. In general, this means reducing missed treatments and scheduling extra treatments when clinically appropriate (e.g., for fluid overload) both of these measures are clearly better for our patients. Pharmaceutical companies are interested in bringing effective new therapies to market that will benefit our patients. Since I have finished my fellowship, there have been multiple new classes of medications that have proven effective in treating various forms of kidney disease. There are also multiple promising treatments in development that will give us even further therapeutic options. Professional organizations like the RPA want to work to benefit nephrology practices and their patients. Paying dues and getting active in the organizations helps them fulfill that goal.

**Understand Your Patients’ Needs**

When I finished my fellowship, I thought the most important thing to patients was getting a technically accurate diagnosis for their disease and the most up-to-date, guideline-based treatment. I find in practice that patients are looking for a doctor that will explain in plain language what is wrong with their kidneys, calm their fears about their kidney disease (many patients seeing me for the first time are scared that I’m going to immediately start them on dialysis), explain the rationale for appropriate treatments for their kidney disease, and teach them what they can do themselves to help their kidneys (such as dietary changes). I think it’s also important to understand our patients as people — we should involve their families in disease management and learn what’s important to them (e.g., work, family, travel, hobbies). Our patients may choose a less effective treatment for their kidney disease if it means that they can continue doing something meaningful in their life, so we should understand this and support them in making that trade-off.

**Take Care of Yourself**

As I mentioned above, the RPA annual meeting last week was rejuvenating as I was able to interact with my fellow nephrology professionals from around the country and share our struggles over the last several difficult years. I’m leaving in a few days for a week in California with my family, and I’m looking forward to seeing my brother there and taking my children to Disneyland for the first time. Make sure that you take time off from work to be with friends and family. I also encourage you to disconnect during that time — don’t check your work email and electronic health record so you can feel like you are really on vacation.

I’m sure that the practice of nephrology will continue to change and evolve over the next 10 years of my practice. I’ll be better-positioned to adapt to those changes because of my involvement in the RPA. Dr. Conlon has lived in Atlanta with his wife and family for over a decade. After finishing his residency and fellowship at Emory, he joined Atlanta Nephrology Associates where he is now a partner. Dr. Conlon serves as a member of the RPA Board of Directors.
Today, I made a momentous decision. After more than 25 years, I decided it was time to pull the plug. With great trepidation, I made the call to shred the last of our paper charts. In the computer age, with patient records literally at our fingertips, many reading this article cannot conceive of a paper chart. For them, and those of us who leaped into technology, I would like to reminisce about this relic of our past.

In the 1960s, family doctors made house calls, jotting a few rudimentary notes on treatment cards kept in filing cabinets. Still, others, like my childhood physician, kept everything in their heads. He didn't need notes (or a laptop), and he “remembered everything” — until he didn't. Continuity of care bit the dust when our records were buried with him.

Fast forward to the early 1990s when charts were a kindergartener’s dream. Stickers everywhere! Manilla folders shelved in large filing systems sported color-coded stickers for the first 2-3 letters of the patient’s last name and another for the current year. Prominently placed on the front of the chart were more brightly colored stickers, calling attention to allergies and other vital information. We even had colored dots signifying if we were the patient's PCP or specialist in our practice.

Today, no one spends time choosing the exact colors for those stickers. No deciding whether this year’s color is too close to last year's or should we use an “Mc” sticker or an “M and a “C”? We merely enter the patient demographics, the computer assigns an account number, and voila! A patient record is generated right before your eyes. (You cannot call it a chart because there are no pretty stickers).

Gone too are the days spent tracking a lost chart. When one was misplaced, it could be anywhere!

It took SKILL to sleuth out that MIA chart, following its journey through the office. Was it with the nurse, waiting for a note? Maybe it was sitting in the refill stack while someone held it for the pharmacy. Was it in the physician’s dictation basket? Could it be in the charts waiting to be filed? If it was, did someone alphabetize those piles so they could be easily found? If not, kudos to those colored stickers. Worse yet, had someone forgotten their alphabet, and horrors of horrors, it was misfiled!

Then there was the “Black Hole,” otherwise known as the doctor’s desk. Who can forget the stacks and stacks waiting for them to return from vacation? I am sure they can’t. Nothing wipes away the vacation high faster than a desk full of charts to be reviewed on that first day back. (Unless it is frantically searching for a Wi-Fi signal to review and sign off records while watching the family enjoy the beach.)

Tests results and notes are now automatically downloaded via various interfaces directly to our EHR and patient portals or scanned and indexed to the chart. No more burgeoning accordion files full of correspondence received in the mail. No more late-night filing parties with pizza and overtime. No more “it hasn’t been filed yet.” No more excuses — unless you count the spam folder.

Remember those brightly colored stickers for each year? Archiving. Many high school students spent their summer pulling charts with stickers three or more years old and “archiving” them into cardboard boxes to be taken to public storage. Once there, the summer workers would search for boxes that were more than seven years old, a truck arrived at the warehouse, shredded the charts, and they were “purged.” Yes, it was Georgia. Summers were hot, but they got ice cream.

We had a system. We had chart detectives, file clerks, filing parties, a huge filing system, teenagers, and a warehouse. Then came HIPAA!! Suddenly our warehouse wasn’t safe. We rented space to store our old charts securely, and we paid to retrieve them. No more tossing charts in the back of someone’s car. We used a locked suitcase with a key at each end to transport charts from one office to the next. Those suitcases were heavy, and it got old fast. We decided electronic records were the only option. As early adopters, we took the leap.

Our medical records coordinator was assigned to spearhead the project. After much planning, the momentous day was here — we started scanning. Each scanned chart was cataloged, boxed, and “archived” in the secure facility. Two weeks later, our official go-live date arrived. There were five doctors—four to convert. The new doc would be one of the first in his class to have never touched a paper chart. Converting one physician at a time and saving the most resistant for last, we did not deviate from the plan. It was a smooth but lengthy transition, and a year later, we were electronic.

The teenagers came one more time to help catalog and box the remaining charts and send them to storage, where some remain — remnants of a bygone era. Our filing system’s space is now home to three very large cubicles, one of which belongs to our medical records coordinator, now an LPN.

One thing has come full circle in this quarter century of change—the physician notes. Much to the joy of nurses everywhere, physicians stopped handwriting their notes on paper charts and began to dictate into handheld tape recorders. Office managers soon tired of typing those notes, and a whole new industry emerged—transcription. The tapes were picked up, transcribed elsewhere, and the notes returned, signed, and filed on the chart.

The advent of electronic records had physicians typing their own notes into the record. This was a problem because they forgot to teach penmanship in medical school, and keyboarding was also not a priority. But never fear, voice recognition was here! The physicians were saved. They could dictate their notes directly into the computer. Everyone was happy, except the transcriptionist.

It took us a quarter-century to get to this point. It was the millennium. We had a system, we were efficient, and we could breathe. Then came COVID!

We had no choice but to embrace technology at a breakneck speed. It was leap or die, and we leap! Two short years later, look at how far we’ve come. We’ve implemented telehealth and are working remotely. The universal chart is upon us. We virtually meet with colleagues around the country (even at the beach). A new era has begun.

As I bid a fond farewell to our paper charts, I appreciate how far we’ve come, and I look forward to the challenges and exciting changes that future technology will bring. (Fingers crossed for more beach time!)

Marietta Miller is the practice administrator of Georgia Kidney Associates, a role she’s held since 1994. She may be reached at marietta.miller@georgiakidney.com.
**Remote Patient Monitoring and ESRD; AKI vs. ESRD Billing**

**Q** Our practice was approached recently by a company that has a remote patient monitoring system, and they told us we can use it for all of our patients including our monthly outpatient dialysis patients. Is this true?

**A** In 2018, CMS introduced CPT codes intended to reimburse Medicare Part B providers for remote patient monitoring (RPM) services (CPT codes 99453, 99454, 99457, 99458, and 99091). CPT codes 99453 and 99454 are practice expense-only codes for the setup and supply for the RPM device. CPT codes 99457 and 99458 are for 20 minutes of monitoring and treatment management that includes interactive communication with the patient or caregiver during the calendar month, and an additional 20 minute if necessary. CPT code 99091 is for 30 minutes of monitoring each 30 days that does not require interactive communication (i.e., asynchronous communication).

As noted in this question, RPA recognizes that nephrology practices may be exploring use of these services in the treatment of kidney disease, and that vendors of the technology for this family of services are proposing processes for integrating RPM into their practices. It is RPA’s interpretation that these services would be allowable in the treatment of chronic kidney disease prior to dialysis. However, for patients certified as having ESRD via completion of the 2728 form, many of the patient assessment and monitoring activities associated with conditions such as hypertension and volume management would be captured by the scope of services of the ESRD monthly capitated payment (the MCP, CPT codes 90951-90970). However, conditions unrelated to dialysis would qualify for RPM services (possibly such as diabetes management) even in ESRD patients. It is worth noting that CMS has not explicitly prohibited billing the RPM and MCP codes concurrently. Nevertheless, we believe that the physician work activities encapsulated by the RPM codes overlap and that specific tasks within them are duplicative. Therefore, a nephrology practice may significantly increase their exposure to audit risk by billing the RPM codes and the MCP codes on the same patient in the same month. Further, RPA is also mindful that a spike in utilization may result in a review of the family of outpatient dialysis codes, which could possibly lead to a reduction in value for these services.

If your practice chooses to pursue the use of RPM in tandem with MCP, RPA would strongly suggest that: (1) there is clear documentation on what work was done and when (and this is of course always the best approach, in gray areas such as concurrent use of new codes with established codes, it is especially important); (2) the practice ensure that there is a summary of the data reviewed and the medical decision making in your medical record; (3) if accurate and appropriate, the practice include the phrase “could not be handled during dialysis” or similar language in their note; (4) that the RPM note be distinct from the MCP note in the practice’s EHR to emphasize it as a separate activity; (5) that ICD-10 coding be detailed and supportive of the use of RPM in these instances; and (6) that a practice choosing to employ RPM in ESRD patients test use of these codes in a pilot or proof of concept process, including the necessary billing and administrative follow-up, prior to large investments in equipment or workflows.

To be clear, RPA is cognizant of the fact that RPM is now a part of the physician’s health care delivery armamentarium, and that use of these services will likely only increase in the future. However, in the present we urge nephrology practices to proceed cautiously with their use in ESRD care until there is greater clarity from Medicare on concurrent billing.

**Q** We have new start dialysis patients who begin as acute patients, and as you know, some transition to ESRD. When this happens in the middle of the month, is the claim billed as acute care or as ESRD, since the ESRD claim is filed as capitated billing with the date of service being the beginning of the month?

**A** This is a gray area, as like many detailed coding and billing issues in nephrology, there is no guidance from CMS on this specific point. It is also worth noting that when the acute kidney injury (AKI) billing for facilities changed RPA coding experts did have concerns regarding the potential for gaming when AKI services (represented by CPT code 90935) and the MCP (codes 90960-90962 for adults) were provided in the same month. Since there is no specific prohibition on billing both services together, a practice could presumably bill both, even with the same place of service (POS 65 for the dialysis facility). If the practice were to pursue this path, detailed record keeping with specific discussion of the medical decision making involved in the patient’s transition from AKI to ESRD would be advisable if not essential. However, the safest (and simplest) route in an audit sense would be to just bill the MCP, since it does represent care and provide payment for a full months’ worth of service.

**Q** One of our doctors has asked about billing for prolonged services (CPT code 99358, Prolonged evaluation and management—E&M—service before and/or after direct patient care, first hour) in addition to 90935 for AKI patients, because providing care to AKI patients requires more work than for ESRD patients since a lot since a lot of the tasks involved don’t occur during dialysis, such as trying to titrate a patient off of hemodialysis if they are recovering their function, performing and assessing follow-up lab work, etc. Is this allowable?

**A** RPA does not recommend billing these services together. RPA’s coding and auditing experts believe that think billing for non-face to face prolonged care stretches the boundaries of what would be appropriate and would most likely put them at an elevated risk to be audited. If the practice did do this (which again is not recommended), they would want to carefully document the activities on which they spent their time. In fact, these time-based codes really should have a start/stop time or a “total time” documented in the note. To bill this code with any regularity on a preponderance of the practice’s AKI patients would be very risky in our opinion, unless they are prepared in detail to defend what they did for each of those 60 minutes.

**Q** Prior to the emergency covid-19 guidelines, how often did the home dialysis patient need to be seen in person to bill for the month? Conversely, during the emergency covid-19 guidelines, how often does the home dialysis patient need to be seen in person or by telehealth to bill for the month?

**A** On the first question, the answer is quarterly, as of January 1, 2019, after the first three months of care, which do need to occur face-to-face. The Bipartisan Budget Act of 2018 included a provision that changed the requirement from monthly to quarterly, with the remaining two visits in a consecutive three-month period allowed to be provided via telehealth technology (meaning a real-time audio-visual interaction). On the second question, the answer is monthly, as even though the public health emergency (PHE) allows for all services on the approved CMS telehealth list (which includes the home dialysis codes) to be provided via telehealth regardless of originating site or geography, they do have to be seen monthly, whether in-person or by telehealth, to bill for the service.
What is the Value of an RPA Membership, Using Nephrology Reimbursement as a Metric?

The current dues for membership in the Renal Physicians Association (RPA) for adult and pediatric nephrologists is $425; this figure is $275 for advanced practitioners and administrators, and $200 for early career physicians. And while in an era of competing memberships and rising costs for everything, $425 can seem like a lot of money, but did you realize that:

If your services are inpatient oriented and your practice most commonly bills CPT code 90935 (hemodialysis, single evaluation) for the work you do, **your membership in RPA will be accounted for once you have provided this service six times in a calendar year!**

**OR**

If the care you provide is more office based for treatment of CKD, using CPT code 99214 (level four office visit) as a benchmark, **your membership dues will be covered when you have provided this service four times in a calendar year!**

**OR**

If you predominantly provide monthly outpatient dialysis services (in-center or home, adult or pediatric, excluding the single-visit dialysis service, CPT code 90962), **this expense will be completely accounted for after billing for two MCP services of a calendar year!**

**OR**

If you are an interventional nephrologist, **the first time you provide and bill for CPT code 36902 (balloon angioplasty, dialysis circuit) your RPA dues will be covered!**

RPA recognizes that medicine broadly and nephrology specifically is an art in addition to being a science, and that treating patients with advanced kidney disease is a calling and a privilege. But it is worth noting that the cost of your RPA dues in the vast majority of cases is accounted for through the services you provide in the first, second, or third workdays of a calendar year. We urge you to consider these circumstances when deciding to join RPA for the first time. **RPA is the leading organization at work on efforts to ensure that nephrologists are equitably reimbursed for the work they do; please support us in this effort through your membership in RPA.**

Visit [www.renalmd.org](http://www.renalmd.org) to join the Renal Physicians Association. Already an RPA member? Share your RPA experience with your colleagues and encourage them to join.

If you are a renewing member and have tried to pay your dues “online,” but encountered login issues — we sincerely apologize for any issues you may have experienced. Please call Sydney Bullock at 301-468-3515 or Katrina Murray at 301-468-3516 or Rose Butts at 301-468-3534 — we will be able to update your record and take your payment in less than 5 minutes.
Join Us Virtually for Capitol Hill Day and IN-PERSON for the RPA PAL Forum

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MAY 13, 2022

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