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RENAL PHYSICIANS ASSOCIATION

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Renal Physicians Association
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RPA News

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RPA Advocates for Nephrology Priorities during Advocacy Weekend

On September 27, RPA, along with our partners from the American Association of Kidney Patients (AAKP), convened its annual Capitol Hill Day congressional visits program, with 65 participants visiting 99 Hill offices. RPA and AAKP advocates focused on RPA's primary legislative priorities, including both short- and long-term Medicare physician reimbursement reform, extension of the alternate payment model (APM) bonus, and enactment of the Living Donor Protection Act, and also urged enactment of the Kidney PATIENTS Act, the legislation that would extend the exclusion of certain oral only drugs from the ESRD payment bundle.

One of the main highlights of the day was remarks Rep. Yvette Clarke (D-NY, member of the House Energy and Commerce Committee) made during the morning's pre-visits briefing. Congresswoman Clarke has been an original sponsor or cosponsor of almost every one of RPA's legislative priorities during the 118th Congress, and has otherwise been a great friend to the kidney community. She discussed the prevalence of kidney disease in her district (representing Brooklyn), and the urgent need for fundamental restructuring of the U.S. health care delivery system. Rep. Clarke concluded by urging participants to advocate vigorously during their visits and to stay involved with their legislators' offices in the future.

Following RPA Capitol Hill Day, more than 80 nephrologists and practice administrators continued their engagement and education at the RPA Policy, Advocacy, Leadership (PAL) Forum on September 28. Attendees learned about topics such as the impact of Medicare Advantage and nephrology, Cybersecurity, Labor Shortages, and Changes to Transplantation. Attendees also heard from Tom Duvall, Division Director for the Division of Special Populations and Projects in the Seamless Care Models Group at the CMS Innovation Center, on what's on the horizon for value-based care. The day finished up with important nephrology coding and billing updates.

While the date for the 2025 RPA Capitol Hill Day has yet to be determined, please plan to join us in Washington for the event. Over half of the participants were attending their first congressional visits program, and by all accounts, had a great and meaningful experience. Please be part of our efforts to petition the government on behalf of the nephrology specialty next year.

If you are looking for additional coding and billing insights, be sure to view the [on-demand 2024 Nephrology Coding and Billing Workshop](#), and save the date for the 2025 Nephrology Coding and Billing Workshop on April 3, 2025!



Clockwise from top: Rep. Clarke addresses RPA Hill Day participants. First Look Fellow Dr. Fetcher (l) talks with Dr. Mitchell during the RPA PAL Forum. Dr. Doshi speaks during a panel at the PAL Forum. Anika Porter, Suzanne Przybyla, Donna Bednarski and Brittany Armer discuss labor shortages at PAL Forum. Adonia Calhoun Groom, Tom Duvall (CMMI) and Rob Blaser at the PAL Forum.



If You Haven't Heard, There's an Election in November; THANK GOODNESS!

Any communication on legislative issues coming from Washington in the fall of an even-numbered year has to discuss the elections. Apart from the existential aspect, the global impact, and the implications for the future-of-the-American-political-experiment elements of this particular go-round, we are also in the closing months of one of the most do-nothing Congresses ever. And compared to recent years, it's not even close.

A compilation of information from Congressional data sources such as Congress.gov and GovTrack recently made available to RPA (thank you, Kidney Care Partners) that compared totals of enacted legislation in the last five Congresses prior to this one confirms this. The data showed the first and second sessions of the two-year Congresses since 2013 (five Congresses over ten years). The totals for the 113th to 117th Congresses averaged approximately 94 bills enacted in the first session of the Congress and 261 in the second (understanding that the second year will almost always be higher since legislators will have presumably gotten more into their bill passing groove). The totals for the 118th Congress? Thirty-four bills were enacted in the first session and 44 in the second! This is a jaw-dropping degree of inactivity.

So why did this happen? The opinion here is that a primary root cause of the idleness was the slim margin by which Republicans controlled the House and the ramifications of that circumstance. The first issue that caused was the delayed ascendancy of former Speaker Kevin McCarthy (R-CA) to that role. This led to slowdowns in the finalization of committee chairs, committee assignments, and other functional aspects of legislative development, so activities in this area that usually occur in December/January/February were now happening in March/April/May. Additionally, the slim margin compelled Mr. McCarthy to agree to a rule change that would allow any single member of the House to issue a motion to vacate, calling for his removal, leaving him in a most tenuous position throughout his tenure. Then, when he was ultimately ousted after approximately nine months, the crazy thin margin resulted in unsuccessful Speaker runs by several House GOP leaders, leaving the chamber without a Speaker for about three weeks, which was fairly unprecedented.

Another effect of the narrow control is that it provided small factions with disproportionate leverage over proceedings. This applied to the far-right House Freedom Caucus (HFC), the far-left 'Squad', and the middle-of-the-road Problem Solvers Caucus (with members of both parties). However, the Squad generally held their fire on initiatives being pursued by House Democratic leadership, and the Problem Solvers were generally inclined towards governance, leaving the HFC as the most disruptive faction.

This is not intended to let the Senate off the hook. They are regarded by many House members as a legislative graveyard for a reason, recalling the old joke that the real enemies in Washington are not Democrats and Republicans but rather the House and the Senate. However, by its nature and size, the House is unrulier than the Senate and thus much more likely to go off the rails, which it clearly did in the 118th Congress. So, thankfully there's an election coming up; maybe we can get a new body of legislators more motivated to get legislation passed (not that this is something upon which the rent should be wagered).

As to where things stand at press time, a continuing resolution (CR) funding the government was passed surprisingly early (five whole days before a government shutdown!). The CR is in place through December 20, with Congress currently scheduled to return on November 12. However, there is some discussion of bringing back Congress to enact disaster relief in the wake of Hurrricanes Helene and Milton (disaster relief was left out of the CR); this seems unlikely to happen.

So, the government lights are on until mid-December, but the list of things left undone is lengthy. Congress needs to pass a reauthorization of the National Defense Authorization Act (NDAA), a farm bill, disaster relief, presumably foreign aid, a debt ceiling fix, and dadgummit, a Medicare package. While the amount of work left to do before COB 2024 is daunting, paradoxically, it could be good for the issues medicine cares about in that there will be numerous vehicles to which provisions addressing our concerns could be attached—as long as discussion of those issues doesn't suck the air out of

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the room—although there is reporting that the committee of jurisdiction has developed drafts of provisions on Medicare extenders.

To recap, the highest priorities for RPA and organized medicine would include a Medicare physician payment fix, extension of telehealth flexibilities (seemingly assured), and renewal to some degree of the alternate payment model (APM) bonus structure (this has been tied to a doc pay fix in the recent past). On Medicare reimbursement, the guess here is that, as in recent years, the full 2.8% reduction would not be restored but rather something like half that would be provided. To be clear, all of medicine is fighting hell-bent-for-leather to get a Medicare Part B payment revision that is tied to the Medicare Economic Index (MEI) included. For 2025, it would provide a 3.6% payment increase, but the cost for this would be in the billions and thus is a challenging pay-for. There is also a bill on Part B payment that would raise the threshold at which budget neutrality in the fee schedule would be triggered, which is clearly a good thing. But its prospects are unclear, and it's not as if such a provision would provide new money.

Regarding telehealth, there seems to be a remarkable degree of certainty among Hill staff that the telehealth flexibilities will be extended. In multiple discussions during RPA's Capitol Hill Day on September 27, the usually cagey senior Hill staff expressed little doubt that a telehealth extension (whether for one year or two) would occur. As for the APM bonus, the whispers are that the early drafts of the year-end deals do include some extensions. Recall that last year's Omnibus bill extended the bonus for the 2024 PY, but at a reduced rate of 1.88%, down from 5% when originally created. It then was changed to 3.5% in late 2022. Of course, this issue is particularly important for nephrology, given the specialty's ties to Medicare and the pertinence of the kidney payment models. RPA will continue lobbying aggressively for its extension.

Interestingly, one of the DC prognostication emails regarding a year-end package that RPA staff regularly receives listed their three most likely provisions to be included in such a deal to be: (1) a physician pay fix, (2) a telehealth extension, and (3) in something of a surprise, the legislation providing a renewed exclusion of oral-only drugs from the ESRD Prospective Payment System (PPS) bundle (!). This is a testament to the

effectiveness of the advocacy efforts around the Kidney PATIENTS Act (S.4510/H.R.5074), which RPA has endorsed. While there are miles to go before we sleep on the December legislative packages (hat tip to Robert Frost), this bill having that high of a profile is certainly encouraging.

The primary living organ donor bill (S.1384/H.R.2923, the Living Donor Protection Act) also remains a fascinating situation. All normal metrics point to the bill having a great shot at being included in a December omnibus, including good cosponsorship numbers (at press time, 42 in the Senate and 212 in the House), minimal advocacy opposition on the merits of the issue, and committed Congressional staff leading the internal Hill effort. However, complexities with the mechanics of the legislation (largely related to the 'five-committee' problem referenced in previous *From Capitol Hill* columns) have some of the Washington insiders knowledgeable about the bill discussing a strategy for next year already. For its part, RPA, along with our partners from the American Association of Kidney Patients (AAKP), lobbied hard for the living organ donor bill on our September 27 Hill Day. Further, given the congressional scrutiny of the organ and transplant allocation systems in the U.S., it would not be shocking to see something organ donation-related be enacted this year.

Lastly, the final disposition of prior authorization (PA) legislation (S.4518/H.R.8702, the Improving Seniors' Timely Access to Care Act of 2024) will be intriguing to observe. As with the living organ donation bill, it has a lot of support in Congress (while it only has six cosponsors in the Senate, that number is 205 in the House) but also has to overcome opposition from the health insurer community. That said, the PA advocacy community pursued an intensive advocacy campaign since Congress came back from the August recess, with discernible success, adding 23 cosponsors in the House in September alone.

Whichever of these bills that are not enacted will almost certainly be reintroduced in the 119th Congress, and let's hope that the pace returns to typical levels for the benefit of the nation, health care delivery, and kidney care. It seemingly can't get much worse (knock on wood). Please be sure to vote in the elections (it is the minimum degree of civil engagement in our society), and have a safe, healthy, and happy holiday season.

Are you ready to take your leadership to the next level and help shape the future of nephrology?

We are now accepting nominations for the RPA Board of Directors. Serving on the RPA Board is an incredible opportunity to influence key policies, drive strategic initiatives, and ensure the continued success of our organization. As a Board member, you'll play a vital role in advancing RPA's mission, advocating for the nephrology community, and contributing to meaningful discussions that impact the future of our profession. If you're ready to make a difference and bring your expertise to the table, nominate yourself or a colleague today! **The nomination deadline is December 2.**

Learn more at
www.renalmd.org/page/BoardNomination2025

Live Advocacy Update: Continuing Toward Our Vision of Optimal Kidney Care for All

As I return from our first in-person Capitol Hill Days in several years and an excellent lineup of topics at RPA's Policy, Advocacy, Leadership (PAL) Forum, I can't help but reflect on our mission statement: Empowering the Kidney Community through Education and Advocacy. It is precisely what this past weekend was about. We sincerely appreciate our partnership with the American Association of Kidney Patients (AAKP), whose collaboration was instrumental in amplifying our shared agenda on The Hill. The participants walked away with renewed enthusiasm that collectively, we truly can make a difference in our patient's lives.

Another significant venue that weekend for in-person dialogue was the PAL Forum, chaired by Durham Nephrology Associates Dr. Ted Shaikewitz. The conference successfully spotlighted several critical topics on Medicare Advantage, cybersecurity, and value-based kidney transplant models of care that remain top of mind for our membership. It fostered a lively exchange of ideas and strategies to advance our mission until our next gathering at our Annual Meeting on April 3-6, 2025, in Las Vegas, Nevada!

If you couldn't attend in person, don't worry—there are still numerous ways to engage with the issues that matter most to us as the current congressional session comes to a close. There remain important action steps you can take to help us all.

First and foremost, we need to fix the payment structure to ensure we remain available for our patients and deliver the vital care that can delay the progression of their disease. Our

lead advocacy goal in unity with organized medicine is to rectify the Medicare payment structure. Equitable reimbursement to match the expense of running our practices is crucial for providing our patients and staff with the peace of mind they deserve.

Especially in an election year, it is crucial you know where your congressional leadership stands on these issues. Familiarize yourself with their positions and don't hesitate to reach out via email or phone call. Many of our first-time visitors to RPA Capitol Hill Day were surprised at how uplifting advocacy can be, and your congressional representatives need to hear from you now more than ever! It's essential to ensure they are co-sponsoring the bills critical to our cause and so important for our patients. We are heading into a lame-duck session, but there is much work to be done. But we are confident with the right support, we can gain the momentum we need to make a real difference in the areas of payment, living organ donation, and investment in future research and innovation in our field.

Check in with your representatives. Are they members of the Kidney Caucus? Why not? What about the Doctors Caucus? We seem to have some of our closest colleagues retiring after this Congress. Who will take their place? The composition and leadership of this caucus directly impact our advocacy work and are due for big changes after the election is over.

As we forge ahead, your active participation—whether in person or from afar—remains crucial. Together, we can ensure that our voices are heard and that significant strides are made towards better kidney care for all.

I want to make a special shoutout to our two Early Career Public Policy Fellows, Hanna Webb and Jake Nysather, who will end their year serving with the Board of Directors. You have been outstanding additions in sharing your perspective and with whom it has been a privilege to advocate alongside. I also want to recognize our First Look Fellows, who will conclude their term at the end of this year - Abigail Bradner, Rami Bzeih, Buckley Fechter, and Kiran Munir - I hope this experience has inspired you to stay involved in kidney policy and provided you with insights into the many ways to practice nephrology.

As we enter into another contentious election season, thank you for your continued dedication to our cause. Let's keep pushing for the changes necessary to provide the best possible care for our patients and support for our practices.

As always, I remain a dedicated listener and welcome your communication. But don't just **email me**... consider contacting your Representative or Senators too!



Keith Bellovich, DO
RPA President



Katie Kwon, MD, Erich Ditschman, MS, and Keith Bellovich, DO in front of the US Capitol on RPA Capitol Hill Day.

A Sneak Peak at 2025

2025 is just a few months away and we are already deep into RPA 2025 Annual Meeting planning. Slated for April 3-6, 2025, in Las Vegas, NV the buzz of something good to come is all around. Building off our 50th Anniversary celebration at the 2024 Annual Meeting in Baltimore, we have learned that interactivity and networking are important components of a successful meeting. While there may or may not be karaoke in 2025, there will definitely be opportunities to bring our community of professionals together, hear timely content, network, and refresh for the important work to be done. RPA appreciates being a vehicle to connect the kidney community to decision makers, innovators, policy and rule makers to address those areas that hinder your ability to deliver the highest quality of care in service of patients with kidney disease.

So what should we expect at the 2025 Annual Meeting? It begins with a great venue in the JW Marriott Las Vegas Resort and Spa. Just minutes from the Las Vegas Strip and Red Rock Canyon, the JW Marriott is a Mediterranean-style, serene retreat near all the action but far enough away from the hustle and bustle. With several onsite amenities to accommodate almost any interest, the resort is a great place to learn, relax and share memorable experiences with your colleagues and friends. Only 16 miles from Harry Reid International Airport (LAS), whether you decide to stay close to the resort or venture on to the Las Vegas Strip, attendees will be able to create an experience that suits their individual needs and goals.

The RPA Education Committee co-chaired by Drs. Katie Kwon and Samaya Anumudu has worked incredibly hard to bring top notch education, innovative learning formats and opportunities to recharge. Priding ourselves on our under one roof meeting layout, attendees will be able to join morning gatherings intended to promote wellness and help de-stress, interactive sessions that will veer away from the same old didactic lectures, and a host of social opportunities to bring together peers of similar interests and encourage new connections. Shared learning sessions, open format workshops where you can brainstorm ideas for your most pressing challenges amongst your peers, and short presentation style formats to encourage emerging voices and create opportunities for those who may not commonly or be the most comfortable presenting are all new additions along with the great content you are used to at the RPA Annual Meeting.

The opening session Louis Diamond Keynote lecture will kick off with Dr. Anna Gaddy, nephrologist at Froedtert Hospital and Medical College of Wisconsin, Milwaukee, and living kidney donor who will share her journey and thoughts on recapturing the joy of medicine. The RPA 2025 Annual Meeting will carry a theme of work life balance to bring forth the timely need for social, emotional well-being, and safety for those who care for patients and work in the nephrology space.

There will be a new, interactive meeting app deployed ahead of the meeting to help build momentum, gauge attendee interests for planning and discussion purposes, and encourage networking and community building as the meeting approaches. Our goal is to have everyone leave the RPA Annual Meeting recharged, reinvigorated, and reinforced with new knowledge for the return to the important work of

kidney care. Gratitude is due to the entire RPA Education Committee for their thoughtful and dedicated efforts to ensure the RPA community is receiving quality education, networking, and tools to support their practices and well-being. Meeting registration will open in early November. Early bird registration closes December 31, 2024, so be sure to register early for the best rates. Visit the [RPA website](#) for additional meeting details, deadlines and engagement opportunities as information unfolds.

Beyond the Annual Meeting, RPA has also been working to increase opportunities for input and engagement. Two open opportunities for member participation are the [RPA Board of Directors Nominations](#) and the [RPA Leadership Development program for Early Career Nephrologists](#). The Board of Directors welcomes nominations from those members engaged in the organization who would like to take their volunteerism and leadership lens to the next level. The RPA Board of Directors is responsible for the overall management of RPA while determining long-range goals and strategic direction in pursuit of our vision of optimal kidney care for all. The RPA Leadership Development Program is a one-year opportunity for nephrologists who have completed their fellowship and have been in practice 5 years or less. Leadership Development Program participants will be selected by early February 2025 and spend the rest of 2025 engaging with the RPA Board of Directors developing a greater understanding of policy issues related to kidney care and the workings of the RPA. Both opportunities have an application deadline of December 2, 2024.

RPA received a great response to the recent call for First Look Fellowship applicants. Be sure to check the January issue of RPA News to learn more about our 2025 incoming class of fellows. Additionally, thank you to everyone who applied to be a part of the RPA Digital Communications Task Force. RPA was pleased by the outpouring of interest to serve. As RPA continues to implement our strategic goals to pursue inclusive expansion, innovate to thrive, and champion a sustainable profession, look out for increased group, short-term and one-time volunteer opportunities to contribute to our vision in pursuit of optimal kidney care for all. Governance service is open to RPA members all year long so please [view our committee options](#) and consider joining one today.

I will end by encouraging everyone to renew your RPA membership. If you have a colleague who is not a member and needs a little encouragement to join, please share the reasons you engage with RPA and why you find your membership valuable. As the landscape of kidney care continues to evolve, we need the kidney community and our stakeholders to band together, find alignment and continue the fight for the challenges and opportunities that impact you. Visit www.renalmd.org to renew or invite your colleagues to the RPA community today!



Adonia Calhoun Groom,
CAE, CMP
RPA Executive Director

RPA Honors and Remembers Dr. Chaim Charytan

1938-2024

Dr. Charytan served as President of RPA from 1997-1999 and was instrumental in founding the RPA PAL Program (then known as NCAP). He was a dedicated contributor to many RPA initiatives and governance groups. He will be missed, and his legacy will continue to inspire us.

I first met Dr. Chaim Charytan in 1978 during the early days of my internship at Jacobi hospital, Albert Einstein College of Medicine in the Bronx. Quite simply, during those early months of my training Dr. Charytan taught, me and I am sure many of my fellow interns, how to be physicians. It was not so much that he demystified and unlocked the marvels of the kidney (though he certainly did do that), but rather the education he provided as our role model and mentor. When Dr. Charytan "made rounds" he had one thing in mind — the patient. He taught us how to make sure our care plans were understandable and could actually be accomplished by our patients. We learned how to ask clear questions and to try to better understand what was important to our patients. He taught us to listen.

Largely because of his influence, I both became a nephrologist and joined the RPA, where I learned his approach to quality and advocacy, which was identical to his approach to patient care. He staunchly believed that advocacy should always focus on doing what was best for our patients. As the New York advisor to the Medicare carrier, he discovered that Medicare coverage decisions differed in every state, meaning patients' access to medications and treatments differed everywhere. To address this clear inequity, Dr. Charytan and the RPA founded the Nephrology Carrier Advisory Panel (NCAP; now Policy Advocacy Leadership) and advocated for harmonized coverage for dialysis patients across the county. This action was typical of his approach to other challenges: focus on the patient and quality. Dr. Charytan exemplified the mantra that the purpose of advocacy is to improve the quality of care for patients.

Chaim was an outstanding physician, role model and mentor. We will all miss him greatly. His legacy of compassion, warmth and his steadfast commitment to providing the best care possible for our patients will influence care for many years to come. May his memory be a blessing.

- Renee Garrick, MD

Chaim was an official witness at my wedding, always a kind and thoughtful friend. He was reliably willing to share his insights about anything RPA. Chaim was always beaming when talking about his family.

- Jim Weiss, MD

What a leader, colleague, and friend for ages.

- Ed Jones, MD



Dr. Chaim Charytan at RPA's 50th Anniversary Gala in April 2024.

He was the best! He was always attentive to the specific needs of ped nephrology as well as to nephrology as a whole. I am so glad I got to see him and visit again at the RPA 50th. He will be missed.

- Eileen Brewer, MD

Sad to hear of Chaim's death, but when we were last together at RPA's 50th, we were reminiscing about our time at the Harvard RVS study and the fact that what would now be called The MCP flunked. He said he enjoyed work and was going to do that as long as possible. Sounds like he got his wish, Thanks God!

- Dick Hamburger, MD

A crossing of the rainbow bridge by a gracious mentor is deeply saddening.

- Bill Owen, MD

Chaim was one of my first RPA mentors, and I can picture first meeting him back in the early 1990s at an RPA event somewhere in the southwest. I always remembered how he made a point to talk to me (there weren't many junior nephrologists, let alone "girls" there) and explain why it was important to be involved (little did I know, how involved one could be)! Years later, NCAP was formed, giving many of us an added opportunity to become involved and, moreover, learn how to have effective interchanges with payors in regard to local issues. A special note is that Chaim and I shared the honor of being married to transplant patients. He will not be forgotten.

- Becky Schmidt, DO

Chaim's deep voice of reason will be missed.

- Chet Amedia, MD

In March of 2000, my son James was born, a week before the RPA Annual Meeting held in DC that year. About a week after that, a box arrived at our door (it was a bigger deal then, in the pre-Amazon era), and it was a teddy bear for James, from Chaim. In addition to being a clinician leader in so many ways, Chaim was also an incredibly thoughtful man.

- Rob Blaser

Mental Health for Working Parents in Medicine: Letting Go of Perfectionism

As we consider the epidemic of physician burnout, we have to take into account the impact of a parent's struggle with mental health. The U.S. Surgeon General, Dr. Vivek Murthy, has issued a call to arms to rally behind the importance of parental stress and their mental health. I readily admit that my return to work has been a difficult adjustment. We have everything we could want. Yet, I could not have expected how challenging this transition would be. After all, we have a beautiful, healthy boy. We have a robust support system and a practice that has supported me through IVF and pregnancy. I set myself up for success - How hard could it be? In this article, I plan to explore some of the challenges parents face as they navigate their return to work and highlight what we can do to bolster working parents in medicine.

We in the medical profession are hardwired to demand perfection—from ourselves and in our care for patients. Before parenthood, my ego and youth allowed me to pursue this impossible standard. Yet, as an early career physician, I realize a huge part of my growth has been learning how little power we have to control our patients' outcomes.

But nothing humbles us as parenthood does. We learn how to execute a new set of complicated logistics and find that things rarely go as planned. I mistakenly assumed I could be the same professional I was before becoming a parent. Yet, with the split demands of home and work, the cycle of stress and guilt, as well as numerous sleepless nights—I found myself losing pace at work and overwhelmed with shame when I could not perform to my own standards. I was isolated by the pressures of being a new parent and engulfed with guilt for not being present for family milestones. The collision of these identities raised enough self-doubt to question whether I should continue in medicine.

How do we free ourselves from these expectations and shift our standards to something more reasonable? When I was in medical school, my mentor was asked, "How do parents succeed in medicine?" She glibly answered, "Learn to accept that you may fail at everything." While I was first dismayed by this advice, it has taken on a new perspective. My mentor was attempting to normalize the image of the working parent. She was encouraging us to shed the mindset of perfection, find grace, and treat ourselves with flexibility and understanding. It is through our "failures" that we learn and develop compassion to be better doctors.

When I pause to reflect on what I want, I realize I want a fulfilling relationship with my partner and kids above all else.

Therefore, does it become inevitable that my identity as a nephrologist comes second to my new responsibilities as a mother? Despite this rearranging of priorities, I remain fully committed to my job. But I also feel empowered to set boundaries. I am learning to ask for help, delegate, and accept mistakes with curiosity. I still have a lot to learn. I used to believe that asking for help was an admission of incompetence. I now view it as a strength to recognize our limitations as well as our strengths and weaknesses.

During my first few weeks back at work, the head of my practice sat down with me. I had joined a practice of male nephrologists, and it had been a long time since they had to transition a first-time working mom. He earnestly said, "You cannot get help if you do not ask for it. If you wait for others to help without your own asking, you will be disappointed." Therefore, we must lobby early and communicate often. But I also ask for practices to initiate these conversations. With the perceived stigma surrounding mental health, it is difficult to admit when we are struggling. And in many ways, the mental health struggles health professionals contend with are the very same that parents experience. Schedule monthly meetings with your staff and check how they are adjusting.

I hope this editorial helps others forge a new culture that embraces working parents. I challenge each of us to talk openly and participate in the collective responsibility of supporting mental health. Offering employees the opportunity to attend to their needs allows them to be more focused while working and creates the best-performing teams. When we invest in people, we invest in their future, and we invest in our practice's future.

Editor's Note: This is part of a series of articles aimed at "early career nephrologists" and represents Dr. Kurtz's perspective. This column does not represent the views of the RPA.

Dr. Elizabeth Kurtz completed her Bachelor of Science at Carnegie Mellon University in Pittsburgh, PA. She attended Yale University School of Medicine for her MD. She subsequently completed her Internal Medicine residency at Massachusetts General Hospital and her Renal Electrolyte Fellowship at the University of Pittsburgh Medical Center. She joined private practice with Tereadesai, McCann & Associates, P.C. in Pittsburgh, PA, in 2022.



Elizabeth Kurtz, MD

Advance Your Skills with the RPA Leadership Development Program for Early Career Nephrologists

The RPA Leadership Development Program for Early Career Nephrologists is a one-year opportunity for nephrologists in practice 5 years or less. Program participants will develop a greater understanding of policy issues related to kidney care, as well as the workings of the RPA, through participation in RPA Board of Directors meetings, conference participation and committee engagement. Program participants will be mentored by a member of the Board and will have the opportunity to write for the RPA News or another publishing opportunity. [Learn more and apply today!](#)

Operational Data: The Practice Manager's Perspective

Every month, financial statements and reports are produced and sent to physicians and management within a practice. These reports may include charges, claims, operating expenses, and more. This information can be challenging to decipher when you are focused on working directly with physicians and patients in the office. What does this information mean? How does it affect the day-to-day workflows of an office? How can I, as a manager, utilize this information to make positive changes in my practice? These are all questions I have found myself asking when reviewing the information presented each month.

As a practice manager, I have discovered that there are key metrics for each office position that can be monitored regularly to help improve and measure staff performance and their contributions to the practice's bottom line. This information is useful for explaining and evaluating trends in revenue or expenses and for conducting annual performance evaluations of staff. It can be reviewed by position in the office, such as front-end staff, clinical office staff, and Advanced Practice Practitioners (APPs). Every staff member plays a crucial role in the success and outcomes of a practice. Determining which metrics to follow depends on the practice's annual initiatives and goals.

Front-end staff are essential in setting the stage for a patient's visit and overall experience with the practice. As a patient arrives for an appointment, the information collected at the front desk is critical for billing, scheduling, consent, and patient contact. Key measurements for evaluating the efficiency of the front desk staff include the collection rate of HIPAA forms, co-payments collected on the day of the appointment, and practice consent forms signed on the day of the appointment. Monitoring these items can enhance communication with patients and improve their overall experience. Additionally, collecting and entering insurance cards into the EHR will facilitate billing processes. As a manager, tracking these metrics will help identify any roadblocks in the process and provide tools for staff training, ensuring they succeed to the best of their ability. Setting annual goals with periodic updates for staff helps maintain transparency and engagement as you work to implement new initiatives.

Clinical office staff members, who interact directly with patients, gather important clinical information that supports physicians in performing efficiently and effectively. Typical duties include reconciling medications, taking vitals, and updating medical and surgical histories. Measuring the percentage of collected or reconciled information provides an indication of the clinical team's productivity. Additionally, monitoring response times to tasks assigned by physicians can further assess productivity. Collecting accurate clinical data enables physicians to evaluate patient conditions effectively, thus improving practice productivity, efficiency, and patient satisfaction. This efficiency helps to decrease overall expenses, while also increasing revenue through accurate documentation of patient comorbidities and visit complexity for billing. If there is a trend of decreased office

visit complexity, a key place to start reviewing would be the collection and monitoring of clinical information from the clinical office staff.

APP productivity can be assessed in various ways depending on their utilization.

For instance, if APPs are primarily assigned to dialysis patients, tracking the number of notes entered per month can measure efficiency and productivity. In practices where APPs work in multiple settings (e.g., hospital dialysis, office), productivity can be measured using Relative Value Units (RVU) or a matrix of agreed-upon metrics. For example, a new consultation in the hospital typically requires more time than a follow-up visit and should be weighted accordingly in productivity assessments. Other metrics to monitor include APP's assistance with documenting and billing HCC codes or proper billing of office and hospital charges based on patient complexity. Establishing annual benchmarks or goals and maintaining regular communication about progress can help ensure that these metrics are met. The capture of four (4) visits with the assistance of the APP's will directly impact the information seen on financial statements and reports. Additionally, the proper coding and billing for the office and hospital patients by their complexity will also impact these reports and statements. Monitoring the APP's monthly and annual productivity will assist the practice to ensure that the APP's are appropriately contributing at the top of their license and operating in the most effective way to the practice's success.

Timeliness and consistency in communication regarding each staff member's metrics help to maintain continual engagement throughout the year. Quarterly updates for each staff member assist both management and employees as the year progresses. These periodic updates help leadership step in to provide additional education or training when necessary. The purpose of following each metric is not only to track productivity of staff but to adjust daily workflows to impact the financial statements and reports given by other departments in the organization. At the end of the year, the annual performance evaluation, which includes a cumulative review of the year's metric goals and outcomes, helps to provide direction for the upcoming year.

Operational data related to patient care impacts the revenue and outcomes of a practice. The data can be outlined according to the practice's strategic plan, with metrics carried over or adjusted year to year. For instance, collection of annual consents might be a consistent metric, while billing for complexities may be revised. Overall, the practice should align its goals with the efforts of staff in the office, hospital, or dialysis centers to achieve these objectives. Continuous



Brittany Armer

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Why A Growing Number Of Nephrology Practices Are Converting To Multi-Specialty Practice

In today's rapidly changing healthcare environment, more single-specialty practices are transitioning to multi-specialty models. This trend is especially relevant for specialties like nephrology, vascular surgery, radiology, cardiology, and podiatry, where integrating multiple disciplines can improve patient outcomes and operational efficiency by ensuring that practitioners treating common co-morbidities experienced by endovascular patients are housed within the same practice. Nephrology practices, in particular, stand to benefit from this transition since managing chronic kidney disease (CKD) and peripheral arterial disease (PAD) often requires coordinated care from various specialties to prevent complications and enhance overall patient care and satisfaction.

Real-World Example: A Multi-Specialty Approach to Caring for CKD Patients

Consider a 65-year-old patient with CKD who also suffers from PAD and diabetes. In a single-specialty model, a nephrologist might focus exclusively on kidney function, while podiatrists, vascular surgeons, and radiologists focus on PAD care, wound care, revascularization, diabetes management, and diabetic neuropathy. This disjointed approach can lead to fragmented care, delayed interventions, poor interdisciplinary communication, and a higher likelihood of complications and amputations.

In contrast, in a multi-specialty practice, nephrologists work closely with complementary specialists to develop a comprehensive treatment plan to delay the onset of late-stage CKD and ensure that patients receive seamless, coordinated care. This improves outcomes and enhances patient satisfaction by reducing the number of appointments and decreasing the need for multiple, often repetitive and costly, diagnostic tests.

Rationales for Transitioning to Multi-Specialty Practice

1. Potentiation Effect

When specialists collaborate, the combined efforts often yield better results than working separately. For example, nephrologists can work with podiatrists to manage diabetic foot ulcers, while interventionalists can address circulation issues related to dialysis patients' vascular access. This integrated care model can improve patient outcomes and prevent complications.

2. Competitive Advantage

Multi-specialty practices can leverage a broader range of services to negotiate better contracts with payers. A multi-specialty practice focusing on CKD care, which also offers complimentary services, can present itself as a comprehensive provider. It is particularly attractive to an increasing number of payers seeking a "one-stop shop" to provide care for their members.

3. Value-Based Care Opportunities

Multi-specialty practices are better equipped to address value-based care initiatives. Patients with CKD, PAD, and diabetes require ongoing coordination of care among providers. By offering integrated care, practices can reduce hospitalizations and improve key quality metrics, making them more attractive for value-based reimbursement models.

4. Ancillary Revenue Streams

Adding ancillary services like in-house imaging, laboratory services, vascular access management, ambulatory surgery center offerings, clinical research, and foot and wound care clinics not only improves care efficiency but also introduces new, complimentary revenue streams that can help to enhance financial and operational independence.

5. Enhanced Referral Capture

A multi-specialty practice facilitates seamless referrals within the same group. For example, a nephrology practice can address vascular complications in dialysis patients or refer them directly to an in-house podiatrist for PAD-related foot care, improving care coordination and minimizing patient drop-offs.



Jason Greis



Nesko Radovic

Business and Legal Obstacles for Practices to Overcome

1. "Special Snowflake" Syndrome

Some specialists may resist the idea of collaboration, believing their services produce outsized value as compared to other specialties.

2. Addressing Fairness in Compensation Structures

Balancing compensation considerations across multiple specialties can be challenging. A nephrologist's revenue model may differ significantly from that of a podiatrist or vascular surgeon, leading to potential conflict or frustration. To address this, practices should engage a compensation consultant and legal counsel to create transparent, fair compensation models that align with the practice's goals and help to enhance compensation for all specialists.

3. Ensuring that the Organization Qualifies as a "Group Practice."

To fully realize the benefits of a multi-specialty model, it is essential for practices to ensure they qualify as a "group practice" under federal and state regulations. This typically involves meeting specific criteria regarding

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the organizational structure, ownership, and operational methods of the practice. A well-defined group practice not only improves patient care coordination but also enhances the practice’s compliance with legal requirements, which can safeguard against potential violations of federal and state self-referral laws, including the federal Anti-Kickback Statute and the Stark Law.

The Stark Law’s group practice rules require that the practice operates as a single legal entity, functioning primarily as a physician group.¹ This legal entity cannot include informal affiliations formed to share profits from referrals. The group must consist of at least two physicians who qualify as “members” under Stark Law, including physician owners, employees², locum tenens³, or on-call physicians. Each physician in the group must provide a full range of patient care services⁴ using shared resources, and at least 75% of these services must be delivered through the group and billed under the group’s billing number.

The practice must ensure that overhead expenses and income are distributed based on methods established before payments are received. The group also must operate as a unified business with centralized decision-making and consolidated billing and financial reporting. Additionally, no member physician can receive compensation based on the volume or value of referrals, except under specific rules for profit shares and productivity bonuses. These bonuses can be based on services personally performed by the physician, and overall profits can be shared as long as they are not tied directly to the volume or value of referrals. Finally, members must personally conduct at least 75% of the group’s physician-patient encounters.

Maintaining compliance with the group practice requirements is essential to a physician practice’s Stark Law compliance. Key exceptions under Stark Law, such as the in-office ancillary services exception—which protects self-referrals by physicians who are members of the same practice—depend on the practice meeting the definition of a “group practice” to qualify for these protections.

4. **Creating Compensation Structures that are Compliant with Federal and State Self-Referral Laws**

Healthcare providers often develop compensation models that are based on the services performed and the items or services they order, prescribe, or refer. To maintain compliance with federal fraud and abuse regulations, including the Stark Law and the Anti-Kickback Statute (AKS), these compensation structures require careful consideration and planning to comply with relevant statutory exceptions and safe harbors.

Conclusion

For nephrology practices, transitioning to a multi-specialty model can greatly enhance patient care. This shift not only improves outcomes for patients with complex chronic conditions, such as CKD and PAD, but also strengthens the practice’s competitive position in a complex healthcare environment. By embracing multi-specialty care, nephrology practices can ensure better patient care and long-term success.

Disclaimer

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1 42 C.F.R. § 411.351.

2 Under 42 CFR § 411.351, employee means any individual who, under the common law rules that apply in determining the employer-employee relationship (as applied for purposes of section 3121(d)(2) of the Internal Revenue Code of 1986), is considered to be employed by, or an employee of, an entity.

3 Under 42 CFR § 411.351, a locum tenens physician (or substitute physician) means a physician who substitutes in exigent circumstances for another physician, in accordance with section 1842(b)(6)(D) of the Act and Pub. 100-04, Medicare Claims Processing Manual, Chapter 1, Section 30.2.11.

4 Under 42 C.F.R. § 411.351, patient care services means any task(s) performed by a physician in the group practice that address the medical needs of specific patients or patients in general, regardless of whether they involve direct patient encounters or generally benefit a particular practice. Patient care services can include, for example, the services of physicians who do not directly treat patients, such as time spent by a physician consulting with other physicians or reviewing laboratory tests, or time spent training staff members, arranging for equipment, or performing administrative or management tasks.

RPA PAC Awaits New Congress, New Opportunities in 2025

With the conclusion of the current Congress (hopefully occurring before the meat of the December holidays), a new 119th Congress will take the oath of office in early January, and with it, new possibilities will present themselves to the country, to organized medicine, to nephrology, and to the RPA PAC. As noted elsewhere in this edition of *RPA News*, the 118th Congress did not exactly drape itself in glory, so new possibilities and new opportunities will be more than welcome.

Of course, what happens on Capitol Hill in 2025 will be largely determined by the November elections, with polling seeming to indicate as of press time that Republicans have the advantage regarding control of the Senate and Democrats being slightly favored to regain leadership of the House and remain in the White House. If the chalk holds that obviously means the era of divided government would continue, which isn't necessarily a bad thing but does not auger well for progress in one direction or the other. What will be fascinating to observe is that if what's projected above occurs (the generally agreed upon legislative engine in DC—the House—being in Democratic hands, and the gatekeeper/oversight body—the Senate—being under control of the GOP), whether that substantially improves the advancement of legislation over the 118th Congress (granted, a low bar). House Democrats in recent times have had less internal strife than Republicans (especially since the Kevin McCarthy House Speaker race), so they may be able to pass bills that are acceptable to the Senate.

As for PAC activities in recent months, RPA participated in KCP-convened events for: (1) Rep. Greg Murphy (R-NC, member of the Ways and Means (W&M) Health Subcommittee, and ardent leader on achieving Medicare physician payment reform); (2) Senator Martin Heinrich (D-NM, sponsor of the RESTORE Act which would restore Medicare Secondary Payer—MSP—protections for ESRD patients, and who is emerging as a kidney policy leader in the Senate); (3) Rep. Yvette Clarke (D-NY, member of the House Energy and Commerce (E&C) Committee who has cosponsored virtually one of RPA's legislative priorities; (4) Rep. Buddy Carter (R-GA, member of the E&C Health Subcommittee, and original sponsor of the Kidney PATIENTS

ACT, which would extend the exclusion of oral only drugs from the ESRD bundle) and (5) Rep. Glenn Ivey (D-MD, whose district is in suburban Washington and whose staff is deeply interested in kidney issues).

Highlights of the events included Congressman Murphy initially saying that it's anybody's guess what will happen in the lame-duck session but ultimately indicating that some level of Medicare physician pay fix would be provided; Congresswoman Clarke (who was also the guest speaker at RPA's Capitol Hill Day Congressional Briefing) calling for significant federal investment in the nation's health care infrastructure; Congressman Carter opining whether the National Defense Authorization Act (NDAA—about as 'must-do' as any priority, especially to Republicans) might serve as the vehicle for a physician reimbursement relief package; and Congressman Ivey refreshingly talking about the privilege and joy of serving in Congress.

Attendance at events like these gives RPA representatives the opportunity to make sure that the interests of the nephrology specialty are accounted for when key committees and the full bodies of both chambers hammer out legislation affecting kidney care. This groundwork cannot occur without your support. Please contribute to RPA's efforts by [donating to the RPA PAC today](#) or sending a personal check to RPA PAC, 1700 Rockville Pike, Suite 320, Rockville, MD 20852. If you have any questions, feel free to contact RPA's Director of Public Policy, Rob Blaser, at 301-468-3515, ext. 118, or at rblaser@renalmd.org. You can also reach out to the RPA PAC Treasurer, Mary Orgler, at morgler@renalmd.org. As always, the new RPA PAC Board Chair Cindy Corpier, MD, and the entire RPA PAC Board thank you for your engagement, your support, and for being an RPA member.

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.

“Practice Management” continued from page 8

communication of the goals and education are crucial for success, ensuring that staff are engaged, feel supported, and are recognized for their contributions.

Ms. Armer is the Practice Manager of Fort Wayne Nephrology Associates of Northern Indiana. She has been with the practice for 7

years, where she covers 11 physicians and 9 APPs. Ms. Armer actively advocates for and works toward utilization of APPs in Nephrology to alleviate the work burden for physicians during times of staff shortages. In addition, she manages the workflows and performance of 24 office and clinical staff, 9 APPs, and 11 physicians, as well as overseeing the practice in 12 provider offices, 22 dialysis units, and 5 Hospitals for all Nephrology care.



Telehealth, mid-month dialysis facility changes, and F2F requirements for home dialysis patients

Question: I have a question regarding Telehealth visits. I know that in 2025, CMS will be changing the guidelines regarding telehealth visits again, but as of now, does the patient need to be an established patient to be seen via telehealth? After researching, I am getting conflicting answers. I thought after the PHE ended it was for established patients only — that there had to be an established relationship between the provider and the patient. Any information on this would be greatly appreciated.

Answer: Telehealth service is allowed for new and established patients through 12/31/24. Based on the CMS-approved telehealth list ([available here](#)), the new patient codes appear to be permanently covered beyond 2024, but it will be necessary to wait and see what the official guidance is for 2025.

“CMS expanded access to telemedicine services for all Medicare beneficiaries during the COVID-19 Public Health Emergency. CMS will continue to allow the use of telehealth services until December 31, 2024. In addition to existing coverage for originating sites including physician offices, skilled nursing facilities and hospitals, Medicare will now pay for telehealth services furnished in any healthcare facility and in the home”

One other related note: as previously reported, an extension of the most meaningful telehealth flexibilities requires congressional action, and all high-ranking Hill staff with whom RPA has interacted have an unusually high level of confidence that this will happen before the end of 2024.

Question: Our practice has patients that are switching dialysis centers mid-month, so they will have split visits into two different units under two different practice doctors for a given month. For example, we had a patient that had one visit in one unit under one of our practice doctors and then two visits in another unit under another practice doctor for the month of August. Similarly, we had another patient who had two visits in one unit and then switched to another unit and had two additional visits there, also in August. Which MCP codes do we bill?

Answer: In the examples given, the practice can bill for the higher visit levels, as the locale of the dialysis services does not affect the nephrology billing. Services for patients that switch units as described would have no bearing on billing because the practice bills as a group. The practice would always want to bill for the total number of visits completed for the patient for all units.

So, for the scenarios above, the practice should bill CPT codes 90961 (the 2-3 visit code) and 90960, (the 4-visit code), respectively. The practice will need to determine which provider to bill the MCP charge under since possibly two different providers completed the complete assessment during the same month, which can be relevant depending on whether the method the practice uses to compensate providers is based on RVU or productivity, which is an internal issue in the practice.

Question: I was at a meeting recently where it was suggested that peritoneal dialysis (PD) lab notes within dialysis-specific electronic medical records (EMR) system could be used to document home dialysis patients who are not seen face-to-face (either in person or via telehealth) each quarter in billing Medicare using CPT code 90966 (for monthly home dialysis services). Is this correct?

Answer: RPA believes that billing for monthly home dialysis in this manner would definitely expose a practice to heightened audit risk, for several reasons. First, it has always been RPA's understanding that the nephrology practice must maintain its own MCP notes apart from what may reside elsewhere, and it seems unclear that what's included in the EMR system described above would suffice as a practice-specific note.

Secondly, the necessity of seeing home dialysis patients face-to-face quarterly has a higher degree of burden than for in-center patients since Congress passed the law in 2019 allowing telehealth to be used for home dialysis patients in two months of a three consecutive month period, contingent upon the nephrologist seeing the home dialysis patient face-to-face once in the three-month period. There are waivers available in this regard that are discussed below, but that is the current status. And to be clear, RPA strongly believes that all dialysis patients, in-center or home, should be seen on a face-to-face basis at least monthly if at all possible.

Regarding the waiver process, the original CMS regulation includes the following language:

Documentation by the MCP physician (or practitioner) should support at least one face-to-face encounter per month with the home dialysis patient. Medicare contractors may waive the requirement for a monthly face-to-face visit for the home dialysis MCP service on a case-by-case basis, for example, when the nephrologist's notes indicate that the physician actively and adequately managed the care of the home dialysis patient throughout the month. The management of home dialysis patients who remain a home dialysis patient the entire month should be coded using the ESRD-related services for home dialysis patients' HCPCS codes.

At the Medicare Administrative Contractor (MAC) level, Noridian Healthcare Solutions, which administers the Medicare program in much of the western U.S., has the following instructions for applying for the monthly home dialysis waiver, which probably reflects the disposition of other MACs:

Since 2011, CMS has allowed payment of the ESRD Monthly Capitation (MCP) for certain home dialysis patients even when the physician has not actually had a face-to-face visit; this requires an individual waiver at contractor discretion. Starting July 7, 2016, physicians may request this waiver by appending the

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-52 modifier (reduced services) to the appropriate monthly capitation CPT code (90963 – 90966).

Place the words, “No Face-to-Face” in Item 19 (or electronic equivalent). Noridian may request medical records to assess whether the notes support that the **physician actively and adequately managed the care of the home dialysis patient throughout the month. [Noridian emphasis added.]** Noridian expects that **requests for these waivers will be unusual. [RPA emphasis added.]** Source: [Noridian, Waiver of Face-to-Face Visit for Home Dialysis Patients - Coding and Billing](#).

Given those points, RPA would urge nephrology practices to exercise extreme caution when billing for home dialysis services when the patient is not seen face-to-face within a three-consecutive month period.

Editor’s Note: RPA consciously takes a conservative position when providing coding and billing advice to its members since the possible unintended consequence of taking a less conservative approach could be a claims audit with the potential of doing tremendous harm to an RPA member’s practice. This column has been designed as a general information resource. It is not intended to replace legal advice. The responses to the questions submitted to the Coding Corner column have not been vetted by attorneys, and attorneys have not been consulted in the drafting of any of the replies.

RPA RECOGNIZES CORPORATE PATRONS

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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September/October 2024

- ◆ On September 6, RPA joined the American Society of Pediatric Nephrology (ASPN), the American Society of Nephrology (ASN), and the National Kidney Foundation (NKF) in calling on Congress to provide an appropriate level of research funding across Health and Human Services (HHS) agencies, including the National Institutes of Health (NIH), the Centers for Disease Control (CDC), and the Health Resources and Services Administration (HRSA). Topic areas include disease research, awareness, detection, management, and monitoring, and modernization of the Organ Procurement and Transplantation Network (OPTN) and the nephrology workforce.
- ◆ On September 9, RPA submitted comments to CMS on the 2025 Medicare Physician Fee Schedule Proposed Rule. RPA comments among other issues addressed: (1) the current Medicare physician payment crisis and recommended that high-cost supplies and equipment expenses be removed from the payment formula; (2) commended the Agency on the proposal to pay for dental services provided to individuals with ESRD, and; (3) recommended that CMS designate the home as an approved place of service for acute kidney injury (AKI) dialysis, in the wake of the recent ESRD Prospective Payment System (PPS) policy change to cover AKI home dialysis. The final rule on the 2025 Medicare Fee Schedule is expected to be released on or around November 1, 2024.
- ◆ On September 10, RPA and over 120 specialty and state medical organizations called on Congress to provide relief from Medicare Part B payment cuts in 2025 and to provide an inflationary update for future years in the Medicare payment formula. The letter emphasizes the crisis in U.S. physician reimbursement and recommends enactment of H.R.2474, the Strengthening Medicare for Patients and Providers Act (which would address provide an inflationary update based on the Medicare Economic Index—MEI), H.R.6371, the Provider Reimbursement Stability Act, and S.4935, the Physician Fee Stabilization Act (similar bills that would make statutory changes to the fee schedule formal to revise the budget neutrality requirement and provide greater stability in Medicare physician reimbursement).
- ◆ On September 12, the American Medical Association (AMA) sent out an alert to all of organized medicine calling on physicians nationwide to contact their House members and call on them to sign a “Dear Colleague” letter circulated by Representatives Mariannette Miller-Meeks, MD (R-IA) and Jimmy Panetta (D-CA), along with a bipartisan group of physician members of Congress to address Medicare physician reimbursement. The letter urges House leadership to take immediate action to not only stop the 2.8 percent Medicare payment cut scheduled for 2025 but also provide physicians with a much-needed payment update that reflects the inflationary pressure they’re facing running a medical practice.
- ◆ On September 28, RPA participated in the Kidney Community Health Equity (KCHE) Summit. RPA has participated in the KCHE Workgroup, which unveiled the KCHE Framework at the Summit. The KCHE Framework is a public resource aimed at addressing health equity in kidney disease through community partnership and collaboration, cultural competence, education and awareness, and holistic care coordination.
- ◆ The week of October 7, the Department of Health Human Services (HHS) and Baxter co-convened two conference calls to address sterile fluid shortages resulting from the recent hurricanes and provided resources to support patients and providers. HHS circulated a letter with information about the shortage, and the FDA provided their latest updates on the issue. Baxter, the primary manufacturer impacted by the hurricanes, also maintains a website for updates. Additionally, groups such as the American Society for Health-System Pharmacists (ASHP) and HHS have developed guidance documents for how to best conserve or substitute sterile fluids. RPA will continue to share all appropriate resources to membership as they become available.
- ◆ On October 11, at the urging of RPA and the whole of organized medicine, 233 members of Congress signed a Congressional ‘Dear Colleague’ letter calling on House leadership to ensure passage of legislation to address the extremely harmful Medicare physician payment cuts. Specifically, cosigning lawmakers urged that “Congress must stop the 2.8 percent payment cut from occurring in 2025, enact targeted reforms to statutory budget neutrality requirements, and provide physicians with a payment update reflective of inflationary pressures.” During our September 27 Capitol Hill Day, RPA attendees urged their elected representatives to sign the letter of support, noting the critical importance of addressing the physician payment shortfall in a year-end legislative package.
- ◆ In Mid-October, RPA and the entire kidney care community participated in national efforts to disseminate information regarding and otherwise raise awareness of efforts led by the Department of Health and Human Services (HHS) to address shortages of saline and peritoneal dialysis (PD) resulting from recent hurricanes. Highlights from the update were that international supplies were being airlifted into the U.S. to address shortfalls, and that the domestic supply was set to begin being replenished by efforts to restore the functionality of and access to Baxter’s North Carolina facility. Details of the federal updates on these activities as of mid-October are available on the [HHS website](#).

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