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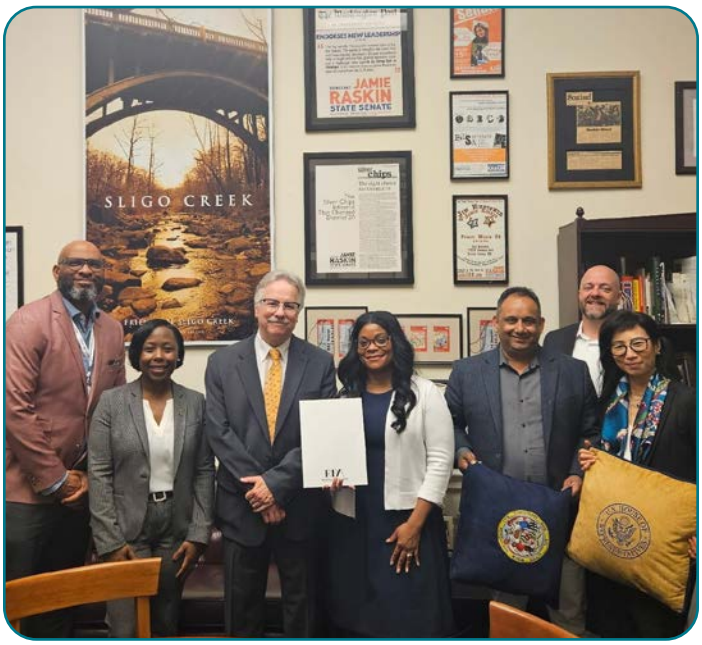
# Despite Government Shutdown, RPA Capitol Hill Day Still a Rousing Success

On October 10, RPA convened its annual Capitol Hill Day congressional visits program, and despite the federal government shutdown, the day was still quite successful in continuing to raise the profile of issues consequential to nephrology and kidney care delivery. Conducted with the partnership of RPA's longtime ally the American Association of Kidney Patient's (AAKP), 66 RPA/AAKP participants visited 85 Congressional offices representing 21 states—about a dozen visits including those for an additional five states were canceled due to the shutdown.

The slate of RPA's 2025 legislative agenda (long-term Medicare physician payment reform, extension of the alternate payment model—APM—bonus, and advancement of living organ donor legislation) highlighted issues discussed with Congressional staff. However, other concerns such as the lack of federal support for innovation in kidney care, nephrology workforce issues, and algorithm-based insurer downcoding of Medicare claims absent medical review were also raised with staff. Additionally, during Hill Day RPA leadership meets with staff from the committees of jurisdiction for the Medicare program (Senate Finance, and the House Energy and Commerce and Ways and Means Committees), and these interactions were fruitful as well. In particular, the meeting with Ways and Means staff, who were very knowledgeable about kidney disease care delivery, was especially productive. This resulted in detailed conversations about the successes and challenges of the kidney care payment models from the perspective of large and small nephrology practices, innovation in kidney care payment via the ESRD Prospective Payment System (PPS), and use of remote patient monitoring (RPM) services in conjunction with the nephrology monthly capitated payment (MCP).

Advocacy is a contact sport, and the kidney community needs the participation of its members and friends to improve Congressional understanding of the positive and difficult aspects of providing kidney care. By all accounts this year's participants had a great and energizing experience. You can too. Please join us in the fall of 2026 RPA Capitol Hill Day and keep engaged with RPA at all our events. We encourage you to **register today for the 2026 RPA Annual Meeting in Atlanta!**




RPA staff and members visit Rep. Jamie Raskin's office (D-MD).

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# RPA AI Summit Highlights Where We Are, Where We Could Be

Artificial intelligence (AI) may be evolving rapidly, but in nephrology, its real-world implementation still has a long road ahead. At the RPA AI Summit held on October 11 in Washington, DC, leaders from across medicine, policy, and technology came together to explore the opportunities, limits, and real-world impact of AI—especially in kidney care.

## Opening Keynote: AI is Only as Good as the Data Behind It

The RPA AI Summit kicked off with a keynote from Virginia Irwin-Scott, DO, who traced the arc of AI from early foundations to its current state in healthcare. Her central message: AI models, no matter how advanced, are only as effective as the data and context they're built on.

With more than 30% of the world's data residing in healthcare—much of it locked away in siloed or unstructured formats—Dr. Irwin-Scott emphasized the need for AI systems to be meaningfully integrated with clinical data if they're going to move from novelty to necessity. To underscore both the potential and pitfalls of today's tools, she shared a story that had the audience laughing: after training her AI assistant to build a risk model for synthetic patients, it delivered results on day two—only to greet her with "New number, who's this?" by day three. A perfect metaphor, she noted, for the state of AI today: promising, impressive, but not quite ready to go it alone.

## AI State of Play: Promise, Pitfalls, and Physician Perspective

A lively panel of four physician-leaders— Qasim Butt, MD, Natalia Khosia, MD, Stephanie Toth-Manikowski, MD, and Alice Wei, MD (all representing different AI companies) and moderated by Tim Fitzpatrick, Founder of Signals Group—shared experiences implementing AI in kidney care and how different AI technologies, including predictive modeling, scribing, voice agents are being utilized as well as challenges in doing so. The panel returned often to the balance between efficiency and authenticity, and the need for tools that enhance rather than homogenize clinical voice.

Additionally, they noted that while predictive models are increasingly robust, the bottleneck is in implementation. "Tools are great if someone will pay for it," Dr. Wei said, highlighting the gap between innovation and reimbursement. Even with CPT codes, like the one created for AI-based diabetic eye exams, viable commercial models remain elusive. Fragmented data systems and regulatory complexity continue to slow scale.

The panelists emphasized the challenge of adoption when practices don't have baseline metrics or clear ROI. Their call for physician advocacy—especially around payment reform and AI design—drew enthusiastic applause.

The panel's shared vision for AI? One rooted in partnership—between physicians, data scientists, and health systems—to ensure tools augment rather than replace human expertise. A simple but powerful

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framework emerged: predict, summarize, prioritize, and parse. If done well, AI could finally lift some of the administrative weight off clinicians' shoulders, letting them focus more fully on patient care.

## The Legal Landscape: New Risks, New Responsibilities

The audience then heard from Nicholas Adamson, JD, Benesch Healthcare +, on AI regulation. He delivered a reality check: the law is scrambling to catch up with the technology. With federal progress stalled, states like Texas, California, Utah, and Colorado have taken the lead—passing legislation that mandates AI disclosure, documentation, and human oversight.

But as Mr. Adamson warned, these new rules may shift more accountability onto providers and systems using AI. "It's not enough to know what your AI can do—you have to know what your state expects you to know." He highlighted recent legal action in Texas, where a state attorney general settled with an AI vendor over misleading claims, setting a precedent for enforcement under existing consumer protection laws.

Mr. Adamson offered four practical best practices for AI governance:

1. Define clear internal policies around AI use.
2. Secure patient consent where appropriate.
3. Update contracts and business associate agreements (BAAs) to address AI-specific risks.
4. Vet vendors thoroughly, including their data practices and safeguards.

His message was clear: AI isn't a silver bullet—it's a tool. But it's a tool that demands continuous oversight, legal awareness, and thoughtful implementation.

## Clinical Workflows: Amplifying, Not Replacing, Physician Judgment

In a standout talk, Adam Weinstein, MD, explored how AI is evolving from a documentation shortcut to a partner in chronic disease management. Framing AI as offering "infinite memory and contextualization," he showed how large language models (LLMs) can synthesize lab results, parse unstructured notes, and even propose next steps in complex cases like CKD.

He outlined three promising use cases:

- Risk stratification models to identify high-risk patients early
- Ambient listening tools to reduce documentation burden
- Data summarization engines that condense longitudinal patient data

The potential efficiency gains are significant: 20–50% reductions in chart review time and 70% documentation savings. But Dr. Weinstein emphasized the need for guardrails: a human in the loop, data transparency, and ongoing governance. His closing metaphor captured the dual-edged power of the technology: "AI is like an intellectual lightsaber. But without skill and restraint, you can accidentally cut off a limb."

## AI and Payers: Power Without Transparency?

In a critical look at how payers are leveraging AI, Heather McComas, PharmD, from the American Medical Association (AMA), shared findings from the National Association of Insurance Commissioners (NAIC): 84% of insurers now use AI, primarily for utilization management and prior authorizations. Yet, transparency remains lacking—only 25% disclose when AI influences decisions.

One controversial area: AI-driven downcoding. These algorithms often downgrade E&M services without reviewing clinical documentation, creating both revenue pressures and care access issues. The AMA and others have warned that opaque decision-making can deepen the administrative burden for practices.

Ms. McComas also addressed Medicare's new WISeR model—a pilot using AI to pre-screen services for medical necessity. While technically voluntary, it is mandatory in several states, sparking concern over fairness, especially when AI tools are owned by companies that financially benefit from denials.

The takeaway: payers are becoming some of the most sophisticated AI users in healthcare. But without governance, transparency, and physician oversight, that sophistication could undermine trust.

## Closing Panel: AI in the Real World—Where Are We Now?

The final panel painted a realistic picture of AI's adoption across the healthcare landscape. Jason Kline, MD, Dana Mitchell, MD, Vijay Paramasivam, MD, and Adam Weinstein, MD, highlighted the range of experiences and adoption across community and

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# Restoring Trust in Science and Medicine: Strengthening the Voice of Nephrology

A few weeks ago, I met a new patient—Mr. D.—a 58-year-old with stage 3b chronic kidney disease, long-standing hypertension, and type 2 diabetes. He came to my office after years of inconsistent follow-up, having heard "too many mixed messages" about medications. When I began explaining strategies for slowing kidney disease progression or guideline-directed medical therapy—he paused. "I'm not sure I believe all that," he said. "I've read that those drugs have more side effects than benefits. And I don't really do vaccines—I heard they can make things worse for people with weak kidneys." He wasn't hostile or uninformed. He was uncertain. Years of receiving advice from multiple sources, conflicting voices online, and growing skepticism towards medical institutions had eroded his confidence. What he wanted wasn't another study citation—he wanted to know if he could still trust the system asking him to take another pill, get another shot, and believe in science again. In that moment, I was reminded that medicine's greatest challenge today is not just advancing discovery—it's restoring belief.

We have all experienced it. Across clinics, hospitals, and dialysis units, physicians are encountering a quiet but steady undercurrent of doubt. Patients are questioning long-established therapies. Misinformation spreads faster than scientific consensus. Even well-intentioned individuals feel overwhelmed by what seems like ever-shifting guidance. In nephrology, this mistrust has uniquely high stakes. Our patients face chronic, often life-altering illnesses that depend on early intervention, shared decision-making, and confidence in the reliability of evidence-based care. When trust weakens, adherence drops, complications rise, and preventable progression accelerates. Patients like Mr. D. don't just test our medical knowledge—they challenge our ability to bridge the gap between science and human understanding.

Our instinct as physicians is often to respond with more data—to show the graphs, the eGFR curves, the meta-analyses. But trust isn't rebuilt by statistics alone. It grows through empathy, attentive listening, and a transparent partnership that puts the patient's well-being above all else. When I explained to Mr. D. that SGLT2 inhibitors were not "new experiments" but part of a long, rigorously validated continuum of kidney and cardiovascular protection, I watched his hesitation ease. We discussed how vaccines, far from harming those with CKD, protect against the infections that can often negatively impact kidney function. We reviewed outcomes—not as numbers, but as stories of people like him who lived longer and better because of early, evidence-based intervention. He eventually agreed to begin therapy and update his vaccinations. But what struck me most wasn't the clinical success—it was how the conversation itself rekindled a sense of trust.

Gary Singer, MD
RPA President

In an era of uncertainty, the Renal Physicians Association (RPA) stands as a stabilizing force—committed to safeguarding the integrity of nephrology and ensuring that public policy, clinical practice, and education remain rooted in science, ethics, and advocacy. For decades, RPA has been the trusted voice of our profession—upholding the principles of evidence-based medicine, physician autonomy, and equitable access to high-quality care. Today, that mission feels more urgent than ever.

Joining RPA is more than affiliating with a professional organization—it's making a personal commitment to uphold the values of scientific rigor, transparency, and compassionate, patient-centered care that define nephrology. RPA membership connects physicians who believe that professional integrity is the foundation of public trust. It allows us to:

- Speak with one unified, credible voice on legislative and regulatory issues that impact kidney care.
- Develop and share best practices that improve patient outcomes and counter misinformation.

- Mentor the next generation of nephrologists to not only practice medicine but to defend it.

In a landscape where confidence in healthcare is fragile, being part of a trusted organization like RPA strengthens not only our advocacy but our identity as stewards of science. Restoring trust in medicine will not happen through press releases or policy alone—it will happen through the quiet, consistent work of physicians who refuse to let cynicism define our field. Nephrologists are uniquely positioned to lead this restoration. We walk with patients through lifelong illness, guiding them through complex treatment decisions, dialysis initiation, and transplant eligibility. We are witnesses to both the science and the humanity of care. RPA equips us for that leadership. Through its educational programs, advocacy, and national presence, RPA ensures that when nephrologists speak—whether in a clinic room, a public forum, or on Capitol Hill—our message is credible, coordinated, and compassionate. The public may not see every policy battle or reimbursement reform we fight for, but they feel its effects every time their nephrologist has the time, resources, and evidence to provide the care they deserve.

Mr. D. returned three months later, proudly showing me his blood pressure log and lab results. His eGFR had stabilized, and he had begun telling his wife and friends about "these new kidney medicines that actually work." That moment reminded me that trust, once rebuilt, multiplies. It moves outward—from one patient to a family, from one clinic to a community. As nephrologists, we hold that power in our daily practice. As members of RPA, we hold it collectively—transforming individual credibility into a national force for evidence-based advocacy. The journey to rebuild trust in science and medicine is ongoing, but we do not walk it alone. Through RPA, we reaffirm that nephrology remains a field where evidence meets empathy, and where every decision—clinical or political—is anchored in truth and integrity.

So I invite you to engage, advocate, and lead. Join the conversations, attend the forums, speak with legislators, and mentor younger colleagues. Let RPA serve as both your professional home and your platform for advancing trust. When we unite around science, compassion, and integrity—trust doesn't just return. It thrives.

**RPA Summit Highlights Where We Are, Where We Could Be** *continued from page 4*

academic practices and dialysis facilities. Panelists described custom GPTs in clinical decision-making, nursing workflows, and the challenges of scaling AI across a vast network of clinics. They also emphasized the challenges of regulatory complexity and data fragmentation.

A central tension emerged: healthcare is built to avoid risk, yet innovation requires some willingness to embrace it. Rollouts often falter when enthusiasm, infrastructure, or operational readiness are out of sync. During the audience Q&A, the question was raised of what happens when platforms like Epic or Microsoft build competing AI tools? What's the impact on emerging startups—and the clinicians depending on them?

A quick audience poll revealed that while only about a third identified as "early adopters" of tech in practice, nearly everyone was using AI in their personal or professional lives. The implication? Curiosity is growing—and so is readiness.

## Final Thoughts: Now Is the Moment to Shape What Comes Next

Throughout the Summit, one message echoed across panels and disciplines: AI in healthcare is not a matter of if, but how. Whether it takes two years or ten, nephrology will be transformed by AI. The question is whether the tools will be shaped with physicians—or for them.

Now is the time for clinicians, data scientists, and health system leaders to work together, ensuring AI enhances what medicine does best—and takes on what it doesn't. The future of AI in kidney care isn't just something to prepare for. It's something we must actively build.

Visit the RPA Store to download the latest AI resources:
RPA AI Glossary
RPA PHI and AI Guidance

# RPA: The Steady Backbone of Team-Based Kidney Care

When most people think of professional kidney organizations, they picture the large scientific societies that drive research and discovery. Yet behind the scenes, another organization has been shaping how kidney care is delivered every day. The Renal Physicians Association has always been known as the professional home for practicing nephrologists, but the truth is, we are so much more than that. RPA is the operational and policy hub supporting the entire kidney care team—from those delivering care at the bedside to those who make it possible through leadership, advocacy, and education.

Having celebrated 50 years of excellence last year, RPA was founded in the 1970s at a pivotal moment in kidney medicine, as the Medicare ESRD program was taking shape. Nephrologists needed a unified voice to navigate a sea of new regulations and a rapidly changing healthcare system. Over time, as the delivery of kidney care became more complex and team-based, RPA evolved right alongside it. RPA membership now extends beyond physicians to include nurse practitioners, physician assistants, administrators, and other allied professionals. This reflects what we all know to be true: high-quality kidney care is never the work of one individual, but the result of a coordinated team effort.

Much of RPA's impact takes place behind the scenes—in policy meetings, regulatory discussions, and advocacy efforts that rarely make headlines but have a direct effect on how care is provided. RPA's work with CMS, Congress, and payers helps shape the policies that govern the practice of nephrology. Whether we are fighting for fair reimbursement, cutting through red tape, or advancing value-based care models, these efforts impact everyone on the care team and ultimately improve the experience for patients with kidney disease.

Education is central to our mission and one of RPA's most important roles. Our focus remains practical and relevant to daily practice. Programs on topics such as such as medical directorship, value-based care, and clinical operations give members tools they can use immediately. We help practices stay compliant, financially sustainable, and laser-focused on quality. Our educational opportunities bring physicians, advanced practice practitioners, and administrators together around shared goals to tackle challenges as a united front.

Adonia Calhoun Groom, CAE, CMP
RPA Executive Director

RPA also advances practice-based research, exploring how care delivery models, team coordination, and system design affect outcomes. This type of work may not always attract national attention or make headlines, but it drives tangible improvements in how kidney care is managed and experienced by patients. It is the kind of steady progress that strengthens the profession from within.

What makes RPA unique is its ability to connect science, policy, and people. We are the bridge between the clinical and the operational—between what happens in research journals and what happens in dialysis units and clinics every day. Our leadership may not always be visible, but its effects are everywhere: in stronger teams, better systems, and more resilient practices.

As medicine continues to shift toward integrated, value-driven care, RPA's mission has never been more relevant. Our association is built on collaboration, and that collaboration will shape the future of nephrology. Whether it is through advocacy, education, or partnership, RPA ensures that every professional in kidney care is supported and valued.

RPA's influence is not dependent on visibility or being the loudest voice in the room. It is measured in outcomes, teamwork, and trust. Across the country, in practices large and small, RPA's work helps care teams do what they do best: deliver compassionate, coordinated, high-quality care to the patients who need it most. In every sense, RPA remains the steady backbone of kidney care, quietly supporting the professionals who make it possible.

If you are reading this and you, someone in your practice, or another professional you know is not a member of RPA, now is the time to join. Be a part of our community of leaders where every voice in the kidney care team is valued and together, we shape the future of nephrology care.

# We Got the Mean Old Shutdown Blues

Usually, this column begins with some sports analogy that parallels DC political life, or a 1970s-1990s boomer rock reference that tracks with current events, or a pop culture observation that is transferable to legislative developments. Sorry, no such cleverness, self-perceived or not, is coming this month. At press time in early November, here at the RPA offices ***we got the mean old shutdown blues.***

Precipitating this descent into melancholy are events happening (or not happening as it might be) in Congress. As for the backdrop for what is happening on the Hill, recent months have been marked by legislative accomplishment and legislative dysfunction. Whatever one thinks of the One Big Beautiful Bill Act (OBBBA, H.R.1), corralling all the various factions in the House Republican Conference and passing the bill with an extremely tight margin is quite an achievement in a legislative mechanics sense. However, this fact must be balanced with massive cuts to the Medicaid program and other components of the federal social services safety net that were part of the OBBBA, and the accompanying harmful effect on delivery of health care nationally. The dysfunction references the situation at press time, as the federal government shutdown has been going for over three weeks, which really serves no one other than perhaps those in the Administration seeking to further erode the U.S. federal infrastructure. Further, Congress has worked for only twenty of the last 115 calendar days (!). Of course, this has implications for all of the other legislative work Congress should be doing, but there are still clued-in observers in DC who feel strongly that a Medicare extenders bill addressing issues such as telehealth, community hospital funding, and even perhaps living organ donation will happen before the end of the year. For now, this is an if-this-then-that situation so how appropriations is resolved will affect other legislative problem-solving moving forward.

Per what is referenced above, as pen goes to paper the government is shut down with no end in sight. The conventional wisdom is that the Republicans believe that their work is done on a continuing resolution (CR) for federal funding that was passed by the House in late September, and which has been put to a vote in the Senate over a dozen times but has always failed along party lines (recalling that 60 votes are necessary to pass such a measure in the Senate). In contrast, Democrats are dug in on insisting that Affordable Care Act (ACA, or Obamacare) subsidies and other relief from Medicaid cuts be provided or at least be the subject of negotiations. For its part, the White House is vowing to implement deep cuts in the federal workforce if Congressional Democrats do not play ball, and some in DC are calling this a nuclear option. The Democratic response is: (1) that is an empty threat; and (2) the Office of Personnel Management (OPM) has already done its worst in that regard. Further, with the ACA enrollment period upon us, the expiration of the ACA premium tax credits is causing beneficiary costs to explode, lending credence to the Democrats' interpretation that they are winning the messaging war.

Robert Blaser
RPA Director
of Public Policy

As for how this plays out, it will be an extremely fascinating exercise from a political science perspective (not to minimize the substantial harm the shutdown has caused). Typically, Democrats are loathe to shut down the government, while Republicans are much less concerned about reducing the reach and capabilities of the federal governing structure. As such, the GOP almost always takes the blame for a shutdown. However, in this year's model, the Republicans can point to a bill they have passed (albeit on a party-line vote) to keep the government open. That said, this is all in the wake of the OBBBA reductions in federal support for many programs and services to which millions of Americans have become accustomed, in both blue and red states, so the possibility that GOP Congressional leadership (forced in significant part by the White House) has overplayed its hand is real.

This brings us to the question of what happens after the shutdown regarding government funding. The bill the House passed before the end of the fiscal year was a CR that would have (will?) funded the government through November 21, 2025. This was

done to provide an opportunity to reach agreement on the full appropriations process (13 separate bills in all) and is interesting in several respects. First, Republicans hate CRs and Speaker Mike Johnson (R-LA) has said they won't govern using CRs (but sometimes that's the only way forward), and second, House leadership insisted that they would only do a clean CR, meaning no other provisions would be attached to it and it wouldn't be a Christmas tree', but ironically the bill did include the Medicare telehealth and geographic rural adjustment extenders, so it wasn't really clean.

On the effort to get the full appropriations process complete after the shutdown, the battle lines drawn are not only Democrats vs. Republicans and House vs. Senate, but also Senate Republicans vs. House Republicans. Prior to the shutdown the House GOP passed five of the necessary appropriations bills, but these all included massive spending cuts that are a non-starter not only with all Democrats but also many Senate Republicans. While the Senate has not passed any of the appropriations bills, the working drafts including spending levels and, in some cases, increases that are much more palatable to Democrats and also more in line with the typical finding process. All of this disagreement leads to the possibility that full FY 2026 government funding could happen through a CR that for the most part would be based on Biden-era spending levels. This would of course be anathema to House Republicans especially, who not only detest CRs but also Biden-associated funding. That said, if President Trump decided he wanted the shutdown to end and leaned into using a CR, it would probably pass easily given that most Democrats would vote for it. One last factor is that Democrats do not trust the Administration to implement the funding priorities as enacted, which spoils the well especially with the full, normal appropriations process.

Regarding what this means for issues important to RPA and nephrology, first, whatever CR gets passed will likely address the telehealth flexibility extension, the work geographic cost index (GPCI) floor that benefits rural areas, the community hospitals, and the other 'must-do' components. Ideally, this fix will be retroactive to October 1; Congress has typically made such changes retroactive, but the longer the shutdown lasts, it would seem like the greater the possibility that the change would not be retroactive. After that, the guess here is that there will likely be a larger Medicare extenders package passed before end of year that will likely include a longer extension of the telehealth flexibilities. On our 2025 legislative priorities, in Congress' mind they have addressed physician payment for 2026 (but 2026 only, not 2025, and not longitudinally), so the fee schedule/conversion factor almost certainly will not be addressed again until next year. However, there might be openings for extension of the alternate payment model (APM) bonus and advancement of living organ donor legislation. Recall that in last year's all but settled Medicare package that was scuttled due to tweets from Elon Musk, the APM bonus extension and living organ donor provisions were included, in addition to one of the larger physician pay fixes that also included a Medicare Economic Index (MEI) based inflationary adjuster and a two year extension of the telehealth flexibilities. The point being that there is appetite on the Hill to enact provisions like the APM bonus extension and something pertaining to living organ donation. Other relevant issues include prior authorization (PA) legislation, which has traditionally had significant support but always seems to get stymied near the goal line, probably by the insurer lobby, and the RESTORE Act, to address the curtailing of the Medicare Secondary Payer (MSP) provision for ESRD beneficiaries. Both bills are probably long shots—the PA legislation due to the stout and well-funded opposition, and the RESTORE Act because it appears that harm from the Supreme Court decision facilitated change has yet to be demonstrated.

So, while we do in fact have the mean old shutdown blues here in the greater Washington area, if Congress were to get back to work in some semblance or normality, good things could happen for nephrology and organized medicine. After all, it is the season of miracles. Please have a safe and happy holiday season.

# In Times of Change, Remember Your Focus

By Holly Curry, RN BSN CHSP

Nephrology practice is in a state of rapid change. From both clinical and operational management perspectives, renal disease is becoming well recognized for its significant impact on individual and population health alone and in combination with cardiac and metabolic disorders. Value based care and quality initiatives have developed to adjunct care, provide data, and ultimately save money. Along with the technological advances, AI initiatives, political agendas, and financial legislature, it is easy to feel out of sync with the pace of change. Since the Practice Manager's patient is the practice, it is important to establish a framework in which to care for it.

Working in close collaboration with physician leaders and administrators, practice managers can host a yearly operational planning session to help ground the clinical, operational, and financial initiatives of the practice. These plans can provide a reference point for decision-making as well as identify areas for improvement, additional learning opportunities, and optimization.

The following categories (modified from the Pillars of Excellence) and points for consideration can help to provide the framework for practice planning sessions. It is not intended to be all inclusive, but rather a starting point for building your strategy. Our practice utilizes Microsoft Planner to document the categories and tasks along with due dates which can be checked off when complete. Once a foundational plan has been created, many areas can be carried over from year to year and modified to meet the needs of the time or changes anticipated. It is also great for periodic checkpoints throughout the year to regroup and refocus in a proactive approach to daily business.

## Service (Patient/Population-based)

- Review of Mission, Vision, and Values for the practice – the why, how, and what your practice is all about. Assure the values are listed among the appropriate categories to target improvements
- Review and revision plan for policy, procedure/workflows
- Appointment layouts and timing, lab/rad review, triage of calls
- Patient education and navigation pathway through the stages of disease
- Patient satisfaction initiatives and measurement

Holly Curry, RN BSN CHSP

## People (Employee/Provider-based)

- Recruitment and retention activities for physicians, APPs, staff of all levels
- Succession planning for key leadership roles and owner retirements
- Wage review for local, state, and federal comparison by role to establish fair pay structure
- Benefits review and practice/owner contributions
- Annual performance review plans and raise amounts vs COLA increases
- Orientation checklist review, ongoing learning, and annual revalidations
- Education as a core value for all roles
- Celebrations and recognition plans for the year
- Communication pathways: meetings, newsletters, email distribution lists, posters

## Quality (Care Provision Programs)

- Value-based care program initiatives (data collection structure and IT availability, along with clinical initiatives with staff and financial needs to support)
- Between-visit care initiatives (billable and non-billable) of CCM, RPM, TCM, education, home modality assessments
- MIPS and/or payer-based quality initiative enrollment and requirements
- Audits and reporting mechanisms

- Finance
- Annual budget review (looking backward and forward)
- Vendor, rent, and service contract review and updates
- Insurance (payors) contract review
- Major building repair needs and associated costs
- Compliance- documentation audits and education to providers
- Review process and tracking of invoice approvals and payments
- Review and update hardship program for indigent patients
- Review finance reports for tracking and trending of specific program P&L (anemia infusions/ injections, ultrasound program, etc.)

## Operations

- Provider schedules and templates to meet visit cadence needs and consult appointments within established parameters
- Call schedules and applications for the various hospital system requirements
- Safety and security of buildings, staff, and patients including disaster planning and inspection requirements
- IT security, maintenance, upgrades
- Compliance audits such as SRA, SAFER guidelines review, PCI-DSS
- EHR update review and education
- Entity reports to state
- Tracking reports
- Malpractice and liability insurance renewals

## Growth

- Identify and provide outreach to referral sources
- Website forms availability
- Outreach and education to hospitalist and case management departments

## Community

- Social media posts with education and celebration
- Organize community education events at churches and organizations
- Collaborate with kidney organizations to plan screening events
- Host support groups for disorders such as ESRD, PKD, transplant awareness, and organ donation

Most important, set up automatic pathways for:

- Review and due date reminders
- Education and policy updates through CMS, HHS, RPA, MGMA, etc
- Scheduled checkpoints in advance and involve your team

Happy Planning!

*Holly Curry, BSN is a Practice Manager and Registered Nurse in Rockford, IL who is passionate about nephrology, and promotes continuous learning along with teamwork to improve the care and outcomes for patients.*

# CMS Releases 2026 Medicare Fee Schedule Final Rule, Nephrology Slated for +1% Payment Increase

The final rule for the 2026 Medicare Fee Schedule was released by the Centers for Medicare and Medicaid Services (CMS) on October 31, and it was finalized almost exactly as it was proposed. Key elements of the final rule are summarized below.

## Nephrology Impact and Methodological Changes Affecting RVUs

As a result of the rule being finalized, nephrology is still slated to have a projected impact of +1%, and the inpatient/outpatient dichotomy is as it was in July, as the methodological changes for the work relative value units (RVUs, adjusted via what CMS is calling the efficiency adjustment which implements a 2.5% reduction for affected services) and the practice expense RVUs (via changes to the indirect PEs), are still in place. Thus, for example, the approximate -9.4% hit for CPT code 90935 (typically inpatient dialysis, single evaluation) and the approximate +9.0 increase for 90960 (adult outpatient monthly dialysis) are finalized as proposed.

Accordingly, all of the changes to the dialysis code family and to E&M codes are as proposed in July, with healthy increases for outpatient dialysis and E&M services, and corresponding cuts to inpatient dialysis and E&M codes. As such, nephrology practices that provide a higher percentage of inpatient services will be negatively impacted, while practices providing predominantly outpatient services will see payment increases. One change made to the efficiency adjustment proposal is to exempt new codes from the adjustment, a change for which RPA and other groups advocated.

## 2026 Medicare Conversion Factor

Regarding the fee schedule conversion factor (CF—the multiplier for RVUs in the fee schedule expressed as a dollar figure), this too in unchanged from what was proposed, so, quoting the CMS press release on the final rule, "the final CY 2026 qualifying alternative payment model (APM) conversion factor of $33.57 represents a projected increase of $1.22 (+3.77%) from the current conversion factor of $32.35. Similarly, the final CY 2026 nonqualifying APM conversion factor of $33.40 represents a projected increase of $1.05 (+3.26%) from the current conversion factor of $32.35."

Recall that this is the first year of the two-conversion factor system mandated by The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) that gives a higher bonus for qualifying APM participants and a lower increase for non-qualifying Medicare Part B providers.

## Telehealth Provisions

CMS did make some changes in the area of telehealth, but the Agency is not legally authorized to make the significant changes, which would be to extend the waivers for originating sites and geographic restrictions, which are currently suspended due to the government shutdown. This is Congress' responsibility, and while there are rumors at press time that the shutdown could be ending, and the expectation is that the waivers will both be extended and made retroactive to October 1. RPA will report on developments on the shutdown and telehealth as they occur.

## As for the telehealth revisions CMS did make, the Agency press release notes that:

- CMS is finalizing the proposal to permanently remove frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations.
- For services that are required to be performed under the direct supervision of a physician or other supervising practitioner, CMS will permanently adopt a definition of direct supervision that allows the physician or supervising practitioner to provide such supervision through real-time audio and visual interactive telecommunications (excluding audio-only).
- Except for services that have a global surgery indicator of 010 or 090, CMS is finalizing its proposal that a physician or other supervising practitioner may provide such virtual direct supervision for applicable incident-to services

On another issue relevant to nephrology, CMS declined to add what are typically inpatient dialysis codes (CPT codes 90935, -37, -45, and -47) to the approved Medicare telehealth list. In describing the comments CMS received on this issue, the rule states that:

The commenters provided information that these codes are generally used to treat critically ill, potentially hospitalized patients who are best treated in-person rather than via telehealth. These commenters acknowledged that there may be extremely limited

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# CMS's IOTA Model Took Effect July 1, 2025: Implications For Transplant Hospitals and Nephrology Stakeholders

Nesko Radovic, Scott P. Downing and Lauri A. Cooper

On July 1, 2025, the Centers for Medicare & Medicaid Services ("CMS"), through its Center for Medicare & Medicaid Innovation ("CMMI"), launched the Increasing Organ Transplant Access ("IOTA") Model. This six-year mandatory demonstration will continue through **June 30, 2031**, and is designed to test whether performance-based incentive payments for kidney transplant hospitals can expand access to transplantation while preserving or enhancing quality of care and reducing Medicare expenditures.[1]

Participation is not voluntary. CMS randomly selected approximately half of all eligible kidney transplant hospitals ("Transplant Hospitals")—about one hundred in total—across organ procurement designated areas to ensure geographic and demographic diversity. Hospitals with fewer than eleven adult kidney transplants in each baseline year or pediatric transplant facilities were excluded from selection.[2] Participation is mandatory to minimize the potential for selection bias and to ensure an adequate sample size.

Unlike prior kidney models, IOTA directly embeds accountability at the hospital level, while also creating a defined role for "collaborators"—nephrologists, physician group practices, dialysis facilities, and certain post-acute providers—to share in model incentives.

## Performance Domains and Scoring

Transplant Hospitals are assessed annually across three domains: achievement (up to 60 points), efficiency (up to 20 points), and quality (up to 20 points).

- **Achievement.** Transplant Hospital targets are customized to each hospital, calculated by averaging each Transplant Hospital's adult kidney transplant volume (both living and deceased donor) from baseline years and trending forward using the national growth rate. If the national growth rate is negative, a zero-growth rate is applied.
- **Efficiency.** Efficiency is assessed using the kidney organ offer acceptance rate ratio, which compares each Transplant Hospital's acceptance of offered kidneys to expected acceptance rates, with scoring based on national benchmarks or improvement against the Transplant Hospital's prior performance. CMS will pick the method which results in the most points.
- **Quality.** Quality is measured by a composite graft survival ratio, and Transplant Hospitals may also submit voluntary Health Equity Plans addressing disparities around transplantation.[3]

Performance Years ("PYs") run July 1 through June 30. PY1 (July 1, 2025–June 30, 2026) is upside-only, with no downside obligation. From PY2 onward, scoring determines financial adjustments: hospitals with scores of 60 or above may earn up to $15,000 per transplant; those scoring 41–59 enter a neutral zone where no payment is received or owed; and those scoring 40 or fewer face downside obligations of up to $2,000 per transplant.

This neutral zone was introduced to mitigate volatility and stabilize financial exposure for Transplant Hospitals near performance thresholds.

## Attribution and Beneficiary Rules

Attribution of patients to Transplant Hospitals under IOTA is both monthly and dual-tracked. Waitlisted patients age 18 or older are attributed to every Transplant Hospital at which they are registered during

1 *Medicare Program; Alternative Payment Model Updates and the Increasing Organ Transplant Access (IOTA) Model*, 89 Fed. Reg. 96,280 (Dec. 4, 2024), **https://www.federalregister.gov/documents/2024/12/04/2024-27841**.

2 *IOTA Final Rule; Ctrs. for Medicare & Medicaid Servs., Increasing Organ Transplant Access (IOTA) Model Frequently Asked Questions* (Aug. 28, 2025), **https://www.cms.gov/priorities/innovation/innovation-models/increasing-organ-transplant-access-model/faqs**.

3 Initially introduced as a mandatory requirement in the proposed rule starting in Y2, Health Equity Plans are now voluntary for all 6 program years. While addressing discrepancies in kidney transplantation for Transplant Hospitals, there is no fiscal or numerical advantage in devising and submitting a Health Equity Plan to CMS related to the performance and scoring under IOTA.

each month of registration. Transplant patients are attributed exclusively to the Transplant Hospital that performs the transplant.

This attribution system means that a patient may simultaneously be attributed to multiple Transplant Hospitals while waitlisted, but once a transplant is performed, attribution is fixed to the performing Transplant Hospital. This dual approach is intended to encourage Transplant Hospitals to both expand waitlists and increase successful transplants.

CMS provides Transplant Hospitals with beneficiary-identifiable claims data (subject to HIPAA data-use agreements) and aggregate/de-identified data for benchmarking. Transplant Hospitals must also publish waitlist criteria on public websites, notify attributed patients of IOTA participation, and review organ offer acceptance criteria with IOTA waitlisted Medicare patients every six months.

IOTA additionally authorizes Transplant Hospitals to furnish certain patient engagement incentives—including transportation assistance, communication devices, in-home support, mental health services, and immunosuppressive drug cost-sharing assistance—subject to program rules. This includes submitting a written policy for patient engagement incentives that must be approved in advance by CMS.

CMS has published the full list of IOTA participant hospitals and their associated organ procurement entity designated service area available here: **IOTA Participant List (2025)**.

## Collaborator Framework

The collaborator framework is a central innovation of IOTA. Transplant Hospitals who enter into written sharing arrangements with collaborators, including a fixed list of types of providers, including nephrologists, nephrology practices, dialysis facilities, and certain post-acute providers may provide collaborators gainsharing payments when they contribute to the Transplant Hospital's performance. Transplant Hospitals may receive "alignment payments" from collaborators to offset downside losses.

Strict guardrails govern these arrangements. An individual nephrologist or nonphysician practitioner may not receive more than fifty percent of Medicare Physician Fee Schedule ("PFS")–allowed amounts for services provided to attributed patients. A group practice may not receive more than fifty percent of aggregate billings for attributed patients at the TIN level. Hospitals may not receive more than fifty percent of their total downside in alignment payments, nor more than twenty-five percent from any single collaborator.

Collaborator selection must be based on quality criteria and may not directly or indirectly consider the volume or value of referrals. Participants are required to publish collaborator lists, post selection criteria, and maintain detailed payment documentation.

## Implications for Nephrologists and Practices

For individual transplant nephrologists, eligibility for gainsharing depends on personally furnishing a billable service to an attributed patient, and contribution to performance across the three levels of Transplant Hospital domains, with gainsharing capped at fifty percent of that physician's PFS amounts for those attributed patients during the same program year.

For nephrology practices, eligibility applies at the group level, with payments capped at fifty percent of aggregate billings across members for attributed patients.

This distinction has significant contractual implications. Solo nephrologists must ensure their gainsharing is tied directly to their services, while practices must structure agreements to address aggregate caps and internal distributions. Best practices include embedding cap language in contracts, documenting allocation methods, and expressly prohibiting referral-based criteria.

## Interaction with CKCC

The IOTA Model operates alongside the Comprehensive Kidney Care Contracting ("CKCC") tracks of the Kidney Care Choices ("KCC") Model. CKCC attributes chronic kidney disease and end-stage renal disease patients to Kidney Contracting Entities ("KCEs"), while IOTA attributes waitlist patients and transplant episodes to Transplant Hospitals.

CMS permits dual participation but enforces the non-duplication rule, which prohibits participants from receiving duplicative payments for the same services or beneficiaries. Thus, a transplant episode attributed to a Transplant Hospital under IOTA cannot simultaneously

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# December 2025 Critical care, High Level MDM, Downcoding

**Question: Is it allowable to bill critical care codes along with dialysis services? Our doctors think it is ok, but our billing staff wants to make sure they are correct. If it is allowable, how should it be documented? Thank you.**

**Answer:** Yes, there are situations where critical care codes (CPT codes 99291 and 99292) can be billed in conjunction with dialysis services, but care should be taken to both provide the services appropriately and to document the services correctly. First, the definition of critical care is comprised of the following components: (1) direct delivery of care to a critically ill or injured patient when one or more vital organ systems are acutely impaired; (2) that there is a probability of imminent or life-threatening deterioration of the patient's condition, and: (3) high complexity decision making is necessary to treat single or multiple vital organ system failure or to prevent further life-threatening deterioration of the patient's condition that requires your full attention. Routine hemodialysis is not considered critical care; there must be a complicating factor as described above. Critical care is reasonable in an ESRD patient if the dialysis treatment (hemodialysis or continuous renal replacement therapy—CRRT) requires support that can only be provided in a critical care setting, such as when providing HD with pressor support.

Regarding documentation, key issues to address include the nature of the critical illness being managed, the total time spent in management, and the specific activities occurring during the service. These could include the time spent at bedside, time reviewing test results, discussion with staff and other health professionals, documentation time, and time spent with family members when the patient is unable to participate. The designated times for the codes are 30-74 minutes for CPT code 99291, and 30 additional minutes for each additional count of 99292 (i.e., beginning at the 75th minute of the critical care service). The dialysis services represented by CPT codes 90935, 90937, 90945, and 90947 are not included in critical care time, and the physician should make sure a separate note is made for dialysis and all the criteria for billing dialysis are met (such as physical presence during the treatment). Additionally, a "-25" modifier should be appended to the critical care code, and RPA would suggest that separate and distinct time stamps be put in both the dialysis and the critical care notes.

**Question: What type of documentation is necessary to bill for high level inpatient and outpatient E&M services?**

**Answer:** In recent years CMS has made billing for evaluation and management (E&M) services more streamlined in both the outpatient setting (changes made in 2021) and for inpatient services (in 2023). Now billing for all levels of care can be based either on time or medical decision making (MDM). Billing based on time is much more straightforward, and for the level five services about which you're asking, the time requirements in minutes on the outpatient side are 60-74 minutes for CPT code 99205 (new or initial patient visit) and 40-54 minutes for 99215 (established or subsequent patient); for inpatient services the required times are 75-89 minutes for CPT code 99223 (new or initial) and 50-64 minutes for 99233 (established or subsequent). The following clinician activities can be included when totaling the time for a service:

- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically necessary examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other healthcare professionals (when not reported separately)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not reported separately) and communicating results to the patient/family/caregiver
- Care coordination (not reported separately)

Time spent by non-billing team members such as medical assistants, lab techs, office staff, etc., cannot be included in this total.

Regarding medical decision making, there broadly there are three categories or indicators determining levels: the number and complexity of problems addressed at the encounter, the amount and/or complexity of data to be reviewed and analyzed, and the risk of complications and/or morbidity or mortality of patient management.

As for appropriate level five (high level) E&M services, the services must be for one or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or one acute or chronic illness or injury that poses a threat to life or bodily function. The activities or types of decisions associated with a high-level service would include drug therapy requiring intensive monitoring, a decision regarding elective major surgery with risk factors, a decision regarding emergency major surgery, a decision regarding hospitalization, or implementation of a do-not-resuscitate order (DNR) or a de-escalation of care.

One way to delineate between moderate and high-level decision-making in documentation is by using the language of risk, utilizing clear severity-based terminology. These are words or phrases such as stable, worsening, rapidly progressing, unstable, etc. For moderate-level MDM, wording such as "chronic but stable" or "mildly worsening conditions requiring monitoring" could be used. In contrast, for high-level MDM, phrasing such as "rapidly worsening" or "unstable conditions, requiring urgent interventions or hospitalization" would likely be more appropriate.

**Question: I have three questions about that fact that Medicare Advantage plans are repeatedly downcoding our hospital care claims. For one payor claims will be denied within 3 days of transmitting claims, while another will pay, then request medical records, and then request a refund either in full or partially after downcoding. What we cannot get from payors is for them to explain is why—they just state our documentation does not support medical necessity. So, the first question is what is wrong with our documentation, ICD-10 codes, medical decision making (MDM), etc., that is causing this? Second, is it true that including 10-12 ICD-10 codes on your claim can work against you, and cause your claim to be flagged for denial and be possibly downcoded? The third question is how do we get our practice out of this never-ending loop of continually asking for medical records on EVERY hospital care claim?**

**Answer:** On the first question per what's above RPA posits that they're using a cumulative Hierarchical Condition category (HCC) score number to deny the claims if they don't pass a certain threshold, based on an algorithm, but of course it's also about denying payment for legitimate levels of care in hopes of reducing payments. Typically, RPA is seeing claims downcoded due to a combination of the documentation not sufficiently supporting the degree of MDM and/or services provided to patients that have stable chronic conditions with lower risk adjustment factor (RAF) scores.

On the second question, our understanding of the payor process is that if the coding goes into the specific detail on the sub-diagnoses for the types of diabetes, hypertension, kidney disease, etc., the HCC scores should increase and thus the chance of downcoding should decrease, as long as the additional diagnosis codes are appropriately documented and specific to the encounter for that date.

Regarding the third question, we suspect it is for a particular payer, and if they are requesting medical records on all services then most likely the group is billing outside of the bell curve. Typically, what we have been seeing is medical records being requested on billing for CPT codes 99223 and 99233. If the provider does not achieve or pass expected accuracy rate, they will continue to do post payment reviews and possibly expand their review to other CPT codes such as 99232. RPA recommends reviewing documentation prior to sending medical records and sending corrected claims if needed. The practice should identify which clinicians are coding outside of the bell curve. Based on national data it is expected that nephrologists will generally have the following utilization ranges for inpatient services: 60-80% for CPT code 99223 and 25-40% for 99233. Related to this point, RPA strongly urges practices to not automatically downcode services; if practices stop submitting claims for 99223 and 99233 the practice will never get out of the audit. There should be enough claims submitted that are accurately supported by documentation to pass the audit. If the practice is already taking these actions, it should be sure to review the notes that failed and be prepared to appeal, and then reach out to the payer's provider relations department for more information.

***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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**CMS Releases 2026 Medicare Fee Schedule Final Rule, Nephrology Slated for +1% Payment Increase** *continued from page 12*

circumstances in which patients in rural areas may benefit from these services being on the Medicare Telehealth Services List, but that in most cases, these patients would require an in-person visit.

This aligns with comments provided by RPA and other groups on the rule. RPA's comments stated that the organization "supports the use of telehealth and other evolving technologies for many Medicare-covered services and believes in its potential to expand access to care for all kidney patients. However, CPT codes 90935, -37, -45, and -47 all typically describe services provided to hospitalized patients who are acutely ill and, in most cases, require a face-to-face visit. RPA does recognize that there would be value in the 90935-47 code set being available for care provided by telehealth in rural settings, and if there were an exclusion process that would limit its use to care provided in rural settings, that would be reasonable and appropriate. Otherwise, we do not believe that CPT codes 90935, -37, -45, and -47 should be added to the Medicare Telehealth Services List."

## Summary

To summarize, with a few exceptions the rule was finalized as proposed. This includes the controversial methodological changes on work and practice expense RVUs that negatively affect inpatient services and significantly benefit outpatient services. This resulted in a projected nephrology-specific impact of +1% for the specialty. That said, it is RPA's understanding that some surgical/procedural specialty societies will be strenuously lobbying Congress to eliminate the 2.5% efficiency adjustment reduction. This probably has uncertain prospects at best, given the government shutdown and the inherent difficulty in advancing legislative initiatives of this nature. Regarding telehealth, some changes were made to Medicare telehealth policy but at press time Congress has yet to act on the issue of extending the waivers on originating sites and geographic restrictions. RPA will track any developments pertaining to the 2026 Medicare Fee Schedule and will keep RPA membership advised as appropriate.

# Insights from RPA First Look Fellows

**Kiran Goli, MD, MBA, FASN**

Kiran Goli,
MD, MBA, FASN

Participating in the RPA First Look Fellowship was an incredibly collegial and rewarding experience. I had the opportunity to meet wonderful mentors and peers who share an outstanding commitment to advancing kidney care and strengthening our profession. The sessions initiated a meaningful dialogue and provided fresh perspectives on leadership, quality, and advocacy in nephrology.

A highlight of the fellowship was visiting Washington, D.C., to participate in advocacy activities on Capitol Hill. Engaging in policy discussions that directly impact patient care emphasized the importance of physician voices in shaping the future of healthcare.

I highly recommend this program to nephrology fellows interested in developing skills in policy and advocacy, as well as gaining a deeper understanding of how the RPA is helping the nephrology community advance patient-centered care.

**Aman Deep, MD**

Aman Deep,MD

It was a great privilege to be a part of the Leadership Development Fellowship program at RPA. This opportunity helped me learn more about the working of RPA at close quarters. I shadowed the Board during multiple meetings and learnt how the organization functions and decisions are made.

All the Board members and staff members were very accessible, cordial and actively encouraged us fellows to be involved in the working of Board matters. In addition, the Capitol Hill day was a great experience and helped me participate in promoting the welfare of kidney patients and nephrologists at national level. I would wholeheartedly encourage other early career nephrologists to look into this program for promotion of renal care at national level.

**Recognize the achievements of your colleagues by nominating them for the RPA 2026 Recognition Awards!**

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generate CKCC shared savings. Hospitals and practices must therefore maintain separate attribution rosters, ensure independent financial reconciliations, and adopt contractual safeguards addressing overlap.

The IOTA Model also incorporates the standard provisions at 42 C.F.R. part 512, which sets forth the requirements for gainsharing arrangements that apply across all Innovation Center models. These include explicit beneficiary protections (attribution does not limit patient choice), compliance and recordkeeping obligations, CMS monitoring and audit authority, remedial action and termination rights, and procedures for reconsideration and appeal.

The interplay between IOTA and CKCC is further shaped by CMS's elimination of the $15,000 CKCC Kidney Transplant Bonus for procedures performed on or after January 1, 2026.[4] CKCC participants will lose this incentive, while IOTA hospitals remain eligible for transplant-based upside payments.

For further detail, see CMS, **Kidney Care Choices (KCC) Model Request for Applications**.

## CMMI Model Realignment

The IOTA Model's launch is part of a broader CMMI realignment, resulting in a significant shift in the innovation models' landscape. In March 2025, CMS announced early termination of the End-Stage Renal Disease Treatment Choices ("ETC") Model, effective December 31, 2025.[5] In May 2025, CMS terminated the Kidney Care First ("KCF") Model and finalized significant revisions to CKCC, including tighter benchmark discounting, reduced chronic kidney disease capitation payments, and elimination of the transplant bonus. At the same time, among other initiatives, CMMI launched the Wasteful and Inappropriate Service Reduction ("WISeR") Model, which deploys artificial intelligence vendors to identify and reduce improper spending, and proposed substantial expansions of Remote Patient Monitoring ("RPM") and Remote Therapeutic Monitoring ("RTM") reimbursement in the CY 2026 Physician Fee Schedule. [For more information on the WISeR Model, see the September 2025 issue of RPA News]

Collectively, these actions highlight CMMI's evolving strategy: retire underperforming models, recalibrate existing kidney demonstrations, and test scalable, technology-enabled approaches emphasizing fiscal sustainability and equity.

## Conclusion

The IOTA Model represents a fundamental shift in federal kidney policy. By embedding transplant accountability at the hospital level and formally incorporating nephrologists and nephrology practices as collaborators, CMS has redefined the incentive structure for transplant care. Hospitals and practices must carefully structure their agreements, monitor compliance with payment caps and referral prohibitions, and manage overlapping obligations with CKCC under the non-duplication rule.

Against a backdrop of terminated and recalibrated kidney models and the rollout of new initiatives such as WISeR and expanded RPM/RTM, the stakes for transplant hospitals and nephrology practices are high. Success in this environment will require careful planning, contractual precision, and proactive compliance.

The Benesch Healthcare+ team is monitoring these developments closely. Please contact the authors of this article for further guidance tailored to your organization.

*Nesko Radovic, Senior Managing Associate, Benesch Healthcare+*

*Scott P. Downing, Partner, Benesch Healthcare+*

*Lauri A. Cooper, Of Counsel, Benesch Healthcare+*

***Editor's Note:*** *This article is for information purposes only and not to providing legal advice. You should contact your attorney and/or tax advisor to obtain advice regarding any particular issue or problem. The opinions expressed in or through this article are the opinions of the individual authors and may not reflect the opinions of Benesch Friedlander Coplan & Aronoff LLP or any other individual attorney.*

4 *CMS Terminates Kidney Care First (KCF) Model and Finalizes Significant Revisions to CKCC Participation and Payment Framework* (May 28, 2025), **https://www.beneschlaw.com/resources/cms-terminates-kcf-model-and-finalizes-significant-revisions-to-ckcc-participation-and-payment-framework.html**.

5 CMS Announces Early Termination of the ESRD Treatment Choices (ETC) Model (Mar. 14, 2025), **https://www.beneschlaw.com/resources/cms-announces-early-termination-of-the-esrd-treatment-choices-etc-model.html**.

# September-November

- On October 16, the Centers for Medicare and Medicaid Services (CMS) clarified that a **communication from the previous day indicating that all Medicare claims would be held was incorrect.** The clarification indicated that the claims that would be held are only for those services impacted by the expired Medicare legislative payment provisions passed under the Full-Year Continuing Appropriations and Extensions Act, 2025, such as for telehealth and hospital at home services, and which have expired due to the government shutdown. Thus, the vast majority of Medicare claims will be processed and paid as normal. RPA will continue to report on developments related to the shutdown and its impact on kidney care delivery as appropriate.

- As previously reported, new ICD-10-CM codes are now effective as of October 1, 2025. **The list includes the two proposals presented by RPA in 2024 on APOL-1 Mediated Kidney Disease (AMKD) and Immune Complex-mediated Membranoproliferative Glomerulonephritis (IC-MPGN) were successful and adopted into ICD-10 for fiscal year 2026.** The new AMKD codes are (1) APOL1-mediated kidney disease (AMKD) N07.B; and (2) APOL1-mediated (AMKD) Z84.11. The new IC-MPGN codes are (1) N00. B1 Acute nephritic syndrome with idiopathic immune complex membranoproliferative glomerulonephritis (IC-MPGN); (2) N00.B2 Acute nephritic syndrome with secondary immune complex membranoproliferative glomerulonephritis (IC-MPGN); (3) N04. B1 Nephrotic syndrome with idiopathic immune complex membranoproliferative glomerulonephritis (IC-MPGN); and (4) N04. B2 Nephrotic syndrome with secondary immune complex membranoproliferative glomerulonephritis (IC-MPGN).

- On October 2, RPA and 37 other physician organizations urged Congress to enact the Specialty Physicians Advancing Rural Care (SPARC) Act (S.1380/H.R.4681). **The SPARC Act would authorize repayment of student loans for specialty medicine physicians and nonphysician specialty providers of up to $250,000 over six years in exchange for their service in rural communities experiencing shortages of specialty providers.** RPA will continue to track developments pertaining to the nephrology workforce and loan forgiveness and keep membership apprised accordingly.

- On September 25, RPA and a large segment of the kidney community urged Congress to **enact the Living Donor Protection Act (LDPA, S.1552/H.R.4582-4583).** The letter notes that in previous Congresses the LDPA was a single bill but has been split into two this year (for tactical reasons) while the unified approach holds in the Senate. The bill(s) would: (1) enact provisions to prohibit discrimination against living donors obtaining life, disability, and long-term care insurance; and (2) clarify that donors are eligible for unpaid time off from work via the Family Medical Leave Act to complete their donation and recovery. Living donor protection is one of RPA's legislative priorities for 2025 and was an area of emphasis for RPA's Capitol Hill Day on October 10.

- On September 25, RPA and a wide swath of organized medicine called on the Administration to issue **clarifying guidance that exempts physicians from the Proclamation affecting H-1B visas entitled, "Restriction on Entry of Certain Nonimmigrant Workers."** The letter notes that the proclamation implements a $100,000 fee, to be paid by the prospective employer, upon initial application for an H-1B visa beginning on September 21, 2025, but also that the Secretary of Homeland Security can exempt workers whose employment "is in the national interest and does not pose a threat to the security or welfare of the United States." RPA will continue to monitor this issue and keep RPA membership apprised of all key developments.

- On September 12, RPA and over 20 other allied medical specialty societies sent correspondence to the Medicare Center for Consumer Information & Insurance Oversight urging them to exercise their oversight responsibilities **regarding insurer downcoding of E&M services.** RPA is closely monitoring developments regarding downcoding, and the issue was discussed at length at the Coding and Billing Workshop and the Artificial Intelligence Summit convened by RPA on October 11.

- On September 8, **the Kidney Care Access Protection Act (S.2730), was introduced in the Senate by Senators Marsha Blackburn (R-TN) and Cory Booker (D-NJ).** This bill includes some of the provisions that were included in previous iterations of the Kidney Care Partners (KCP) community CKD bill. Per KCP, bill refines the ESRD Prospective Payment System (PPS) to improve access to innovative treatment options; ensures Medicare Advantage supports kidney care innovative therapies; and ensures accuracy and stability of kidney care payment. Introduction of a companion bill in the House is expected in the coming weeks.

- On September 5, RPA and numerous specialty societies called on Congress to **preserve access to affordable federal student loans for medical students and other health professions students.** Specifically, the organizations called on Department of Education Secretary Linda McMahon to use her "long-standing authority under the Higher Education Act to allow medical students to borrow additional Unsubsidized Direct Loans above statutory limits. Maintaining this exception is essential to sustaining the pipeline of future physicians and addressing America's increasing medical workforce shortages." RPA will monitor developments on medical student access to federal loans and keep RPA membership apprised accordingly.

- On August 20, RPA and organized medicine broadly sent a letter to Senate leadership in **opposition to S.2426, the "Equitable Community Access to Pharmacist Services Act (ECAPS) Act."** The letter notes that the legislation 'would inappropriately allow pharmacists to perform services that would normally only be authorized and covered if they were furnished by a physician, test and treat patients for certain illnesses and expand Medicare payment for pharmacists in limited but significant ways." RPA will continue to track issues related to expansion of pharmacist scope of practice and keep membership apprised as appropriate.

# 2026 RPA Nephrology Coding and Billing Workshop

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