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RPA Renal Physicians Association
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Influence and Prepare for the Future at RPA's Advocacy and Innovation Weekend

At the risk of trotting out an old semantic device, there are two types of people in the world: those who let life happen to them, and those who seek to alter the course of events that will affect them. Without wanting to judge (we're all busy), it's far better to be in the latter group than to be passive, and RPA is giving the nephrology community an excellent opportunity to influence and prepare for the future. On October 10, RPA will convene a State of the Nephrology Practice Profession breakfast symposium, followed by RPA's annual Capitol Hill Day. The following day, a condensed RPA Coding and Billing Seminar will be held in the morning, with the afternoon consisting of RPA's first-ever Artificial Intelligence Summit.

Friday's State of the Profession breakfast program will discuss issues such as (1) the future of nephrology practice, workforce trends, needs/gaps, and where private practice is going; (2) physician reimbursement, including a review of the 2026 fee schedule; (3) an update on kidney payment model developments to date, and; (4) Medicare Advantage—nephrology specific challenges. The breakfast symposium is industry-sponsored and wholly separate from RPA's Capitol Hill Day.

As for Hill Day, visiting one's elected representatives (petitioning your government) is almost uniformly exciting and fulfilling. Interacting with key Congressional staff or even the legislators themselves, and striving to influence policy-makers on issues of critical importance to kidney patients and providers is both crucial and stimulating. All attendees have to do is **register for the event** (if attending the entire weekend, only one registration is required) and **request their Congressional visits**; all of the arrangements for your visits will be taken care of for you. There is no fee to attend Hill Day, and for first-timers, it's also easier than you think—it's a matter of telling your story and offering your perspective on issues of importance to nephrology practice to your designated contacts.

Hill Day will focus on RPA's 2025 legislative agenda: (1) Medicare Part B payment reform, addressing both existing shortfalls and longer-term system restructuring; (2) extension of the alternate payment model bonuses; and (3) multiple legislative initiatives intended to promote living organ donation. With good fortune extension of the telehealth flexibilities in place now until September 30, 2025, will have been addressed by then but if not, that would be another issue ripe for discussion.

Saturday will begin with the condensed RPA Coding and Billing Seminar, featuring an interactive discussion-based design; presenters will provide 15-minute summaries on the six topics outlined below, leaving roughly 20 minutes for questions and dialogue on each of those issues in a roundtable format:

- Care Management Code families;
- Revenue Cycle Management;
- Telehealth;
- E&M Billing;
- MCP billing (unique situations);
- Billing in Value-Based Care/CKCC models.

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RPA
Renal Physicians Association

RPA Nephrology Advocacy & Innovation WEEKEND

OCTOBER 10-11, 2025

Washington Marriott Capitol Hill
175 L Street NE
Washington, DC 20002

Member Registration: $329 • Nonmember Registration: $395

A must-attend for nephrologists and practice administrators seeking to advocate, innovate, and elevate the future of kidney care.

FRIDAY, OCTOBER 10

RPA Legislative Advocacy Campaign on Capitol Hill

SATURDAY, OCTOBER 11

Immersive Mini RPA Nephrology Coding and Billing Workshop and immediately following—Cutting-edge Artificial Intelligence (AI) Innovation Summit

REGISTER NOW!

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Registered participants will be queried in mid-September for questions on those topics and whether there are any other issues they would like to see addressed.

The afternoon's program will be comprised by the Artificial Intelligence (AI) Summit. The agenda items at press time for the AI Summit will be:

- A tailored-for-nephrology discussion of the state of play, where leading AI companies will present on their pioneering work, industry insights, and the transformative impact of their technologies on patient care.
- A discussion of the associated legal implications and risks, and the critical legal and policy frameworks governing the use of AI in medicine. RPA's legal counsel will delve into the complex implications and potential risks associated with the rapid advancement of AI technology.
- Discussion regarding the transformative potential of artificial intelligence in electronic health records. From ambient scribing to intelligent risk identification, AI is reshaping medical management. Industry experts will lead a conversation on leveraging AI to streamline workflows, improve clinical decision-making, and deliver more personalized, data-driven care.
- The intersection of prior authorizations and AI will be explored, describing how cutting-edge AI technologies can revolutionize the prior authorization process, and alleviate time-consuming administrative burdens, but with appropriate caution about complexities and challenges to nephrology practice presented by the use of these processes.
- There will be demonstrations of the AI technologies by the presenting AI industry partners throughout the afternoon.

Registration for RPA's Advocacy and Innovation Weekend is open now and please don't forget to request your Capitol Hill visits separately. (Hill visit requests must be received by September 30).

For more information on RPA's Capitol Hill Day or Innovation program please contact Rob Blaser at 468-3515 or by email at **rblaser@renalmd.org**.

INSIDE THIS ISSUE...

Nephrology Breaks Even in 2026 Medicare Fee Schedule with Cuts to Inpatient Care and Increases in Outpatient Service Payment

Proposed Rule includes Fundamental Change

The proposed rule for the 2026 Medicare Fee Schedule was released on July 14, and while the good news is that the conversion factor (CF—and that should be plural because there are now two of them, more on that below) increased, the rule overall is as complex as it has been in years. This is due to CMS' apparent efforts to make methodological changes to reduce the emphasis of the AMA's Relative Value Update Committee's (RUC) valuation of fee schedule codes, affecting both work relative value units (RVUs) and practice expense (PE) RVUs. The result of this is that outpatient services gain substantially in value for 2026, and inpatient services are cut by seemingly equal amounts. As is almost always the case, nephrology effectively breaks even, with a 1% increase in payment projected for 2026.

Proposed 2026 Conversion Factors

As noted, there are now two conversion factors (CF), one for qualifying participants in alternative payment models (APMs) and one for non-participants in models; this structure is a legacy of the Medicare Access and CHIP Reauthorization Act (MACRA) the bill that advanced use of Medicare APMs. The CF for APM participants includes a 0.75% bonus, while the CF for non-participants incudes a 0.25% bonus.

The 2026 CFs also includes the 2.5% increase enacted in the One Big Beautiful Bill Act (H. R. 1) and there is also an upward budget neutrality adjustment of 0.55%. All of this results in 2026 CFs of:

- **$33.59 for those qualifying participants in APMs**
- **$33.42 for all others**

Recall that the 2025 CF is $32.35, so the 2026 APM-based CF will be a 3.83% increase over the 2025 CF, while the 'all others' CF will be increased by 3.30%.

Specialty-Specific Impact

Nephrology is set for an overall 1% increase, but as noted the allocation of indirect PEs in the facility setting will cause a 9% decrease on the inpatient side, and a 7% increase on the outpatient side. Thus, hospital-based nephrologists performing primarily inpatient care will be substantially harmed by these changes, while outpatient care typified by the monthly capitated payment (MCP) for dialysis services will receive a healthy increase in reimbursement.

On a code-level basis, the following chart provides a sampling of the impact on services commonly provided by nephrologists. The calculations below are preliminary and approximate, with the payment amounts based on the 'all others' CF of $33.42.

Additionally, the AMA has disseminated a specialty-specific impact chart based on total RVUs, and it indicates that 71% of nephrologists will either experience little change (-1% to >1%) or will be increased by 2% or more, up to between 10-20%. As noted, the higher the percentage of outpatient work a nephrologist or nephrology practice has in their work mix, the greater the payment increase they will receive in 2026.

Methodological Changes Related to Work and Practice Expense RVUs

Regarding the RUC, the following paragraphs from the Agency's summary on the methodological changes give an indication of how CMS is approaching valuation of services moving forward; the first italicized paragraph addresses the RUC's use of surveys generally and the second discusses the development of indirect practice expenses (PEs).

> *Use of Surveys*
>
> *Only a small portion of the total codes are considered for revaluation annually, and CMS relies primarily on subjective information from surveys that have low response rates, with respondents who may have inherent*

CPT CODE	2025 T-RVUS	2025 PMT	2026 T-RVUS	2026 PMT	% DIFFERENCE
Inpatient Dialysis Services					
90935	2.10	$67.93	1.84	$61.49	-9.4
90937	3.04	$98.34	2.65	$88.56	-9.9
90945	2.57	$83.13	2.30	$76.86	-7.5
90947	3.63	$117.43	3.20	$106.94	-8.9
Outpatient Dialysis Services					
90960	10.60	$342.91	11.19	$373.96	+9.0
90961	8.80	$284.68	9.31	$311.14	+9.2
90962	6.08	$196.68	6.46	$215.89	+9.7
90966	8.80	$310.80	9.30	$384.68	+9.1
90970	0.29	$9.38	0.30	$10.02	+6.8
Interventional Nephrology Services					
36902 (I/P)	7.01	$226.77	6.33	$211.54	-6.7
36902 (O/P)	34.41	$1113.16	35.85	$1198.07	+7.6
36905 (I/P)	12.95	$418.93	11.58	$387.00	-6.6
36905 ((O/P)	64.53	$2087.54	66.24	$2213.74	+6.0
Selected Outpatient and Inpatient E&M Codes					
99213	2.75	$88.96	2.84	$94.91	+6.6
99214	3.87	$125.19	4.05	$135.35	+8.1
99215	5.43	$176.66	5.77	$192.83	+6.2
99222	3.88	$125.51	3.51	$117.30	-9.5
99223	5.17	$167.24	4.69	$156.73	-9.2
99231	1.46	$47.23	1.33	$44.45	-8.9
99232	2.36	$76.34	2.11	$70.51	-10.6
99233	3.52	$113.87	3.21	$107.27	-8.8

conflicts of interest (since their responses are used in setting their payment rates). Research over time has demonstrated that the time assumptions built into the valuation of many PFS services are, as a result, very likely overinflated. To mitigate these effects and take into account changes in medical practice, we are proposing to apply an efficiency adjustment to the work RVU and corresponding intraservice portion of physician time of non-time-based services that we expect to accrue gains in efficiency over time. This would periodically apply to all codes except time-based codes, such as evaluation and management (E/M) services, care management services, ***[Editor's Note: This is good news for nephrology]****, behavioral health services, services on the Medicare telehealth list, and maternity codes with a global period of MMM.*

Revised Indirect Practice Expense Cost Methodology

Specifically, we are proposing to recognize greater indirect costs for practitioners in office-based settings compared to facility settings. The original allocation methodologies assumed physicians maintained separate practice locations even if they furnished some care in hospitals. Since the methodologies were established decades ago, there has been a steady decline in the number of physicians working in private practice, with a corresponding rise in physician employment by hospitals and health systems. Therefore, we believe that the allocation of indirect costs for PE RVUs in the facility setting at the same rate as the non-facility setting may no longer reflect contemporary clinical practice.

Intensive advocacy efforts seeking revision of CMS' broad, 'one-size-fits-all' approach to these changes has already begun, but given that the revised methodology both benefits primary care and aligns with the

Administration's emphasis on reducing use of inpatient services by keeping patients healthier, this will be a challenging endeavor.

Telehealth

On telehealth, there is no discussion of the period after 9/30/2025 (recalling that extension of current flexibilities is a legislative issue to be determined by Congress), but they are seeking to streamline the process for adding services to the approved list. As part of that process, CMS proposes to eliminate the provisional status for codes on the approved telehealth list and is making all codes currently on the list permanent. As a result, the single-visit MCP outpatient dialysis codes which previously were designated as provisional are now permanent. Separately, the Agency received a request that CPT codes 90935, 90937, 90945, and 90947 (the inpatient dialysis codes) be added to the approved telehealth list (this request did not come from RPA), and while CMS is not proposing to do that, they are soliciting comment on the issue.

CMS also proposes that "for services that are required to be performed under the direct supervision of a physician or other supervising practitioner, to 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)."

However, CMS is "not proposing to extend our current policy to allow teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings through December 31, 2025. Rather, we are proposing to transition back to our pre-PHE policy, which requires that, for services provided within metropolitan statistical areas (MSAs), teaching physicians must maintain physical presence during critical portions of resident-furnished services to qualify for Medicare payment. We would maintain the rural exception established in the CY 2021 PFS final rule."

Revisions to the Medicare Diabetes Prevention Program

CMS also proposes a change to the Medicare Diabetes Prevention Program that will allow more people with Medicare to access coaching, peer support, and practical training in dietary change, physical activity, and behavior change strategies to delay or prevent the onset of Type 2 diabetes for people with prediabetes, at no cost to the beneficiary.

Revisions to the Quality Payment Program (QPP)

The proposed rule also includes changes to the Quality Payment Program (QPP), which includes both Merit-based Incentive Payment System (MIPS) and Alternative Payment Models. While most changes are not nephrology-specific, CMS does propose a new MIPS Value Pathways (MVPs) for Interventional Radiology MVP with fistula and graft measures that may be relevant to interventional nephrologists.

MIPS and MVP Changes

CMS is proposing to set the performance threshold at 75 points for the next three years, starting with the CY 2026 performance period/2028 MIPS payment year through CY 2028 performance period/2030 payment year, to provide continuity and stability to program participants.

As previously finalized, beginning with the 2026 performance period, multispecialty groups will no longer be able to report MVPs as a single group. This will mean that if a multispecialty group would like to report an MVP, they must divide into and report as subgroups or individuals. Alternatively, multispecialty groups may continue to participate in traditional MIPS.

To encourage small multispecialty practices to report MVPs, CMS proposes allowing them to continue to have the option of group reporting. They may still choose to divide and report as subgroups to be scored on MVPs. CMS acknowledges that small practices are already resource constrained and requiring them to divide into subgroups would be too onerous. Additionally, subgroups of small multispecialty practices may not meet established case minimums, resulting in lower scores.

Improvement Activities (IAs) Performance Category

CMS proposes to remove the Achieving Health Equity (AHE) subcategory and add a new subcategory entitled Advancing Health and Wellness. CMS would recategorize five existing IAs from the AHE subcategory to other subcategories.

Promoting Interoperability (PI) Performance Category

CMS continues to emphasize the central role of using certified electronic health record (EHR) technology (CEHRT) for earning a score for the PI Performance Category. In addition, the agency highlights that this technology must be certified under the Assistant Secretary for Technology Policy/Office of the National Coordinator (ASTP/ONC) Health

Information Technology (IT) Certification Program and meet the Base EHR definition as well as be certified as meeting additional ASTP/ONC health IT certification criteria.

CMS is also proposing several changes, including adding a second attestation to the existing Security Risk Analysis measure that requires MIPS eligible clinicians to attest "Yes" to having implemented security measures to demonstrate compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 Security Rule implementation specification for risk management. CMS wants eligible clinicians to attest to having implemented security measures to manage their security risk. This second attestation is in addition to the current requirement to attest "Yes" to having conducted or reviewed a security risk analysis. MIPS eligible clinicians would be required to submit two affirmative ("Yes") attestations for this measure to be considered a meaningful EHR user and earn a score for this performance category.

Also included is a proposal to modify the high priority practices Safety Assurance Factors for EHR Resilience (SAFER) guide measure, which requires MIPS eligible clinicians to attest "Yes" to completing an annual self-assessment to the newer 2025 version of the guide, instead of the current 2016 version.

Additionally, CMS is proposing the Public Health Reporting Using the Trusted Exchange Framework and Common Agreement (TEFCA) Measure as an optional bonus measure, adding to the optional bonus measures available under the Public Health and Clinical Data Exchange Objective. CMS is working with the Centers for Disease Control and Prevention, ASTP/ONC, public health agencies (PHAs), and other interested parties to expand the use of TEFCA for sharing health information for public health purposes. CMS believes that facilitating standardized health information exchange with PHAs through the TEFCA Framework has the potential to reduce the reporting burden for MIPS eligible clinicians as well as PHAs. According to the Proposed Rule, MIPS eligible clinicians would be able to claim five bonus points under this objective if they are actively engaged with a PHA to submit data for one or more of this objective's four optional measures, including the Public Health Reporting Using TEFCA Measure.

Requests for Information (RFI)

CMS also included several RFIs in the proposed rule, including:

- Core Elements in an MVP RFI: Feedback on how to encourage MVP reporting on key quality measures that reflect the essential components of an MVP. More specifically, CMS is seeking comments on a potential Core Elements MVP reporting requirement, which would identify a subset of quality measures in each MVP to comprise the MVP's Core Elements.
- Well-being and Nutrition Measures RFI: Feedback on well-being and nutrition measures in QPP, with the goal to provide a more comprehensive approach to disease prevention and health promotion. In addition, CMS is seeking comments on tools and measures that assess overall health, happiness, and satisfaction in life that could include aspects of emotional well-being, social connections, purpose, and fulfillment.
- Procedural Codes for MVP Assignment RFI: Feedback on the use of claims data to assign clinicians to an MVP to help facilitate specialty reporting of MVPs most relevant to their scope of care, including seeking comments on the data sources CMS should consider to utilize to assign clinicians to an MVP and the eligibility determination period to establish procedural code utilizations and relevant volume threshold.
- Transition Toward Digital Quality Measurement RFI: Feedback on the transition toward digital quality measurement and the use of HL7 FHIR standard. Specifically, CMS is seeking comment on the anticipated approaches to FHIR-based eCQM reporting in quality reporting programs and ACOs experience with the transition to FHIR-based reporting of eCQMs and opportunities to mitigate reporting burden.
- Query of Prescription Drug Monitoring Program (PDMP) Measure RFI: Feedback on potentially modifying the Query of PDMP measure in the Promoting Interoperability performance category from an attestation measure to a performance-based measure.
- Performance-Based Measures in the Public Health and Clinical Data Exchange Objective RFI: Feedback on potential updates to the Public Health and Clinical Data Exchange objective

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Charting the Future of Nephrology: Meeting the Moment with Vision and Innovation

It is 4 o'clock on a Saturday afternoon, and I am sitting at the kitchen table reflecting on the challenges facing our field. Seven months into the year, healthcare continues to evolve at a rapid pace, bringing with it both disruption and opportunity. Despite the uncertainty, I remain energized by the transformation happening in nephrology. The Renal Physicians Association (RPA) has never been more vital in helping us navigate the changing landscape of kidney care models and policy reform. Its unwavering commitment to advocacy, leadership, and innovation is why we continue to show up and support this essential organization.

The reality we confront daily includes workforce shortages, burnout, shifting expectations, and recruitment struggles. Nephrology trainees face a complex choice between private practice, employed positions, academia, and industry. For private practices to remain autonomous and sustainable, creativity and innovation are no longer optional—they are essential.

Last month, the proposed rule for the 2026 Medicare Physician Fee Schedule was released, and public comments are due by September 12, 2025. Rob Blaser, RPA's Director of Public Policy, has provided an excellent summary of the proposed changes (See page 4). RPA remains actively engaged in protecting fair, accurate, and sustainable reimbursement for nephrologists. This includes:

- Providing expert feedback to CMS on how proposed changes may impact services such as dialysis oversight, inpatient consults, and care coordination.
- Advocating for policies that reflect the unique intensity and continuity of kidney care.
- Ensuring nephrologists are not penalized by structural reforms to practice expense methodology or valuation changes.

We are also closely monitoring how these changes may affect care delivery models, practice viability, and staffing—especially as we shift further into value-based care. While CMS sets reimbursement policy, Congress plays a critical role in shaping broader reforms. This dual authority makes it essential for nephrology practices to stay engaged at both regulatory and legislative levels. RPA continues to advocate for:

Gary Singer, MD
RPA President

- Continued support for outpatient dialysis oversight reimbursement.
- Greater code-level transparency as CMS modifies payment methodologies.
- Permanent adoption of tele-supervision policies to improve staffing flexibility; and
- Recognition of nephrologists within future population health and value-based care frameworks.

Earlier this year, at the request of Tom Duvall,Director, Division of Special Populations and Projects, Seamless Care Models Group, CMMI, the RPA submitted recommendations for CKCC 2.0. Our suggestions included simplified risk adjustment, broader access for smaller practices, timely payments and transparent reporting, clear attribution and metrics, and the elimination of retrospective changes. Although the most recent guidance on kidney payment models fell short of expectations, RPA will remain engaged with CMMI to advocate for models that truly meet the needs of nephrology providers and patients.

As Medicare Advantage (MA) enrollment continues to rise, nephrologists are increasingly burdened by administrative hurdles that often conflict with the goal of delivering efficient, patient-centered care. While MA plans aim to offer coordination and cost savings, they frequently introduce barriers—especially for vulnerable populations with kidney disease. RPA is leading efforts to push for greater transparency, simplified prior authorization processes, fair reimbursement, and policies that center on the patient.

One of the most forward-looking initiatives RPA is leading is the upcoming Artificial Intelligence Innovation Summit. This event represents a critical inflection point in the intersection of technology and nephrology. With the healthcare industry embracing rapid technological advancements, the summit will explore AI's real-world applications and future potential in kidney care. Keynote speaker Virginia Irwin-Scott will offer a sweeping overview of AI in medicine, and an industry panel featuring leaders from Delorean, Nephrolytics, Healthmap, and Simbie AI and moderated by Tim Fitzpatrick will delve into clinical and operational innovations—from ambient scribing and risk prediction to policy implications and workflow efficiency.

What makes this event especially exciting is the opportunity for member participation. Designed with your voice in mind, the summit offers interactive Q&A, practical discussions, and implementation-focused sessions. Whether you're exploring AI for the first time or already integrating tools into your practice, this gathering promises invaluable insights and collaboration. Together, we are building the future of smarter, more connected kidney care.

As we navigate this transformative moment in nephrology, the importance of staying informed, engaged, and united cannot be overstated. The work of the RPA is driven by the needs and voices of its members—by you. Whether it's shaping policy, adapting to new technologies, or supporting one another through workforce challenges, your involvement is critical to our collective success. I encourage you to participate in upcoming events, respond to policy comment periods, and connect with fellow members across the country. Now is the time to lead with vision, collaborate with intention, and advocate for the future of nephrology. Together, we can shape a stronger future for our specialty—one that is sustainable, innovative, and patient-centered.

Nephrology Breaks Even in 2026 Medicare Fee Schedule *continued from page 7*

within the Promoting Interoperability performance category, specifically on transitioning from attestation-based measures to performance-based measures using numerator and denominator reporting.

- Data Quality RFI: Feedback on advancing data quality—defined as the accuracy, completeness, timeliness, consistency, and reliability of health information—as a foundational element of effective health information exchange.

Summary

While nephrology overall is projected for a typical specialty-specific impact in the 2026 Medicare Fee Schedule (+1%), the foundational changes for determining work and practice expense RVUs will deeply affect nephrology practice, given the negative effect on inpatient nephrology reimbursement and the concomitant increase on the outpatient side. Additionally, these changes may serve as a harbinger for future change in the fee schedule. It must be noted that these changes are for now only proposed, and some stakeholders will be advocating strenuously for some revisions to be withdrawn before implementation. RPA will be monitoring all developments and will keep membership apprised as appropriate.

Comments on the proposed rule are due on September 12, 2025, and RPA's comments will be posted on the RPA website.

Questions on the MFS proposed rule should be directed to Robert Blaser, RPA Director of Public Policy at rblaser@renalmd.org.

Renal Physicians Association: Your Gateway to Excellence in Nephrology Practice

As the voice of nephrology practice and a committed advocate for the kidney community, RPA continues to position nephrology professionals for success. Here are a few updates on what's coming up for RPA in the months ahead. Mark your calendars, stay informed and get involved.

As RPA President Gary Singer and Director of Public Policy Rob Blaser have also outlined in this newsletter issue, ***RPA's Advocacy and Innovation Weekend*** on October 10-11, 2025, in Washington, DC will combine legislative advocacy with cutting-edge education. We hope you will join us to engage with policymakers on Capitol Hill Day, hear the latest in coding, billing, and learn more about artificial intelligence to enhance your clinical practice and drive innovation. **Register for the October meeting weelend.**

RPA continues to expand its educational offerings with the ***RPA Practice Managers (PM) Edge–Empowering Your Nephrology Practice Education webinar series***. This three-part virtual series covers topics to support practice operations right now. Watch the recordings on Chronic Care Management and Managing Your Billing Programs and save the date to save the date of November 12 to participate live in the final 2025 series webinar installment on Balancing the Workflow of the Nephrology Practice. With over 80 professionals signed up, don't miss your opportunity to stay current with practice management challenges and regulatory changes. Learn more and **register for the PM Edge webinar series today**.

RPA governance activities offer members an opportunity to volunteer their time and get involved with shaping the future of nephrology and RPA's direction. ***RPA Committees*** serve as the thought leadership workforce of RPA and provide excellent opportunities to gain knowledge and experience around the organization's many programs and initiatives. RPA Committees implement RPA's evolving strategic plan goals which aim to pursue inclusive expansion, innovate to thrive and champion a sustainable profession. In addition, RPA governance groups advice on emerging policy and regulatory efforts, develop innovative educational programs and provide expertise on practice management in an increasingly complex healthcare environment. Joining an RPA committee is easy and can be done at any point in the year. RPA members interested in governance service should visit the **RPA Governance and Committees webpage** and sign up today.

Adonia Calhoun Groom, CAE, CMP
RPA Executive Director

Two leadership opportunities to look out for before 2025 ends include the RPA Leadership Development Program and RPA Board of Directors nominations. The ***RPA Leadership Development Early Career Nephrologist fellowship*** is a one-year program open to nephrologists in practice five years or less and provides public policy education and exposure along with insights into RPA's governance and membership structure. Participants receive a mentor from the RPA Board of Directors, attend RPA Board meetings, and participate in RPA events and education complimentary during their program year. Funding for this fellowship opportunity is derived from contributions to the **RPA Dale Singer Leadership and Education Foundation** from leaders like you committed to ensuring the nephrology workforce is capable, informed and prepared to address emerging challenges and thrive in nephrology practice. Look out for the fellowship application this Fall and **please give to the RPA Dale Singer Foundation today**.

Nominations for the RPA Board of Directors will also be sought this Fall. With multiple openings available for 2026, the RPA Board of Directors is responsible for the overall management of the society while determining our long-range goals, initiatives, policy positions and ensuring the organization's fiscal health. Each opportunity offers RPA members the chance to

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A Period of Tumult, in Life, and on Capitol Hill

So folks, my apologies for the hiatus of the *From Capitol Hill* column, but sometimes, life comes at you fast. On April 10, I was on a kidney community conference call when I began to feel horrible, with shortness of breath and chest pains. The vast amount of clinical medicine knowledge I have amassed (sarcasm font) prompted me to jump in the car and go to the emergency room (after feeding the dog). Nine days later, I left the hospital after having had triple bypass heart surgery.

My appreciation for the cardiac surgery and cardiology teams at Anne Arundel Medical Center in Annapolis, Maryland, cannot be overstated. The process for my care journey seemed to be as seamless as possible and for a pretty major, life-changing event, that is something for which to have gratitude.

That said, I made sure those folks knew that I worked for nephrologists, that nephrologists are the smartest doctors in the hospital (I mean, please), and that the eyes of nephrologists nationwide were on them to produce a positive outcome (loyal readers of this column know that it is not above embellishment). Anyway, I received a ton of support from the RPA community that I am tremendously thankful for receiving (especially from my fellow RPA staffers, who covered for me in my absence)—how lucky am I to be associated with RPA?

The level of tumult in my personal life was matched by events on Capitol Hill, where big things with huge ramifications for health care delivery and beyond happened. When we last left the Shootout at the OK Corral, Republicans had completed their sweep of the Presidency, House, and Senate, and positioned themselves to muscle through policies reflecting their governing priorities (albeit with very slim margins). And boy, have they. From controversial cabinet nominees (cough, cough, RFK, Jr.), to passage by a single vote of a continuing resolution (CR) to keep the government open in March (more on this below), to enactment of the One Big Beautiful Act (OBBA, H.R. 1), Republican Congressional leadership has had an exceptionally successful opening to the 119th Congress.

Robert Blaser
RPA Director
of Public Policy

First, an observation about this specific legislative session. While every Congress is unique in one way or another, the current 119th body is in rarefied air. One of the hallmarks of the American system of government is the separation of powers among the three branches (Executive, Legislative, and Judicial); however, the current Congress has so far ceded its authority to the Executive branch in a way not seen in recent memory, if ever. This is exemplified by the absence of a challenge from the Legislative branch to the Administration's efforts to impound monies appropriated by Congress to fund priorities determined by the U. S. House of Representatives and Senate, and via the unanimous support the CR passed in March a few weeks ago to fund the government. On the impoundment issue, one of the bedrock principles of our government is that the legislature determines what for and how much regarding federal expenditures, and it is the Administrator's job to carry out those instructions. To the extent that Congressional leadership is not objecting to a freeze in funding for agencies such as NIH, they are ceding their power. For their part Democrats attempted to get language addressing impoundment into the CR, but their efforts were swept aside.

Evidence of shifting funding priorities' impact emerged in mid-July when the Administration's' rescission package defunding the Corporation for Public Broadcasting and several foreign aid initiatives was enacted (per Wikipedia, a rescission bill is a type of bill that rescinds funding that was previously included in an appropriations bill). This was the first successful recissions effort since the Clinton Administration. In addition to this package, there is talk of using a 'pocket recissions' process where the Administration could propose to rescind funding for some already agreed upon spending priorities, doing it within 45 days of the end of the

fiscal year, and if Congress doesn't act, holding the funding. Not only do some experts believe this to be illegal, but it is also an issue where there is some bipartisan Congressional agreement, as Republican appropriators have expressed opposition to use of this maneuver. This is because it not only poisons the well for all appropriations negotiations but also because those Republicans recognize they will not be in the Majority forever and that these tactics could be used by Democrats in the future.

Going back to the political implications of using CR's to fund the government, there are hardline fiscal conservatives that in their Congressional tenures have never voted for a CR. This is based on the entirely rational position that government funding should go through the full regular order, subject-to-sunshine appropriations process. [It is also worth noting that recurring use of CRs is a relatively recent development; 30 years ago, the appropriations process was typically resolved well before the end of the previous fiscal year.] The fact that every Republican but one voted for the CR this time around (and they did not have a vote to spare; two no votes would have sunk the CR), is indicative of the complete control that the current Administration has over the Congressional majorities in both chambers. And given the discord over appropriations currently happening, ironically CR's will probably be used by Republican leadership to fund the government for the foreseeable future.

As for the OBBA (also known as the reconciliation package), there was a long and winding road to enactment that required numerous narrow vote margins (sometimes a single vote), but House Speaker Mike Johnson (R-LA) and Senate Majority John Thune (R-SD) were able to get it done and enact the bill. Leading into deliberations, the problem for congressional Republicans was that they did not agree on what should be in the reconciliation bill. In the House, the measure passed by a single vote, with wide fissures within the party on issues such as the size of Medicaid cuts, rolling back energy credits, and exemptions for state and local taxes (SALT).

As for the Senate, when the Finance Committee released its draft text in June it called for a higher degree of Medicaid cuts (!), a reduced level of SALT exemptions (which was expected to cross a red line for blue state Republicans in the House), and removal of the Medicare physician reimbursement relief provisions. The deleted physician pay language was the House proposal that would have started the process to tie Medicare physician reimbursement to the Medicare Economic Index (MEI) and thus begin to account for inflation in the fee schedule; this is a pretty big threshold to cross. Unfortunately, the provision did not use the full MEI, only a percentage, and that percentage is substantially reduced after the first year of the new method. Instead of using the MEI link, the Senate draft provided a one-time 2.5% increase in the 2026 Medicare conversion factor (CF) and offered no relief for 2025. And while the fee schedule CF will be higher in 2026 than it has been in recent years (much more information on 2026 Medicare physician reimbursement is include in the fee schedule review on page 5), the bill does include deep cuts in Medicaid funding that are of tremendous concern to health care providers across the board. One other note, neither the House nor Senate bill used Medicare site neutral payment reform as an offset (or pay-for), good news for vascular access care for now. In the end, the House was forced to accept the Senate's version of the OBBA legislation, and it was passed on July 3 and signed into law on July 4.

As for what the rest of the year looks like and how things might shake out for the priorities of the RPA, nephrology in general and organized medicine broadly, first, as might be expected, Congress' work on physician reimbursement is likely done for the year. There will be efforts to include a provision to extend the Medicare Alternative Payment Model (APM) bonus provided that some sort of Medicare extenders package happens by year's end, but this is no sure thing. On telehealth, an extension until September 30 was included in the March CR, but the issue was not addressed in the OBBA. This issue is solely up to Congress so action will have to be taken before September 30 to extend the current telehealth flexibilities, but given that government funding ends that date and there is substantial bipartisan support for continuing the current telehealth policies, extension of the telehealth flexibilities now in place could well occur.

Regarding living organ donation legislation, in the Senate S.1552, the Living Donor Protection Act (LDPA) of 2025 was introduced on May 1 and at press time has 28 cosponsors. In the House, a tactical decision was made to split the previous LDPA into two bills for this Congress; the LDPA section is H. R. 4583, and the Family Medical Leave Act (FMLA) section is H. R. 4582, both were introduced on July 22. The splitting of the bills was done to avoid the 'five-committee problem' that has bogged the bill down in

recent Congresses (where five separate committees have jurisdiction over an issue).

On other issues of note, this year's versions of the prior authorization (PA) legislation, the Improving Seniors' Timely Access to Care Act of 2025 (S. 1816/H. R. 3514) were introduced on May 20 and have 53 and 152 cosponsors, respectively. As in previous years both bills have substantial support and would appear to be on a path toward enactment, but this has been the case in the past and did not occur. Additionally, in March the Restore Protections for Dialysis Patients Act (S. 1173/H. R. 2199) was introduced in both chambers; this is the bill that would undo the Supreme Court decision from several years ago and would ensure individuals with ESRD continue to have access to private coverage. The bills have 3 and 33 cosponsors, respectively, and likely quite a way to go before passage.

Writing this column for *RPA News* is usually a labor of love and a cause of some stress until it is completed. Not this month, as I have a different perspective on what stress is these days. Have a great autumn.

Executive Director's Perspective *continued from page 10*

engage with the organization to shape RPA initiatives and goals at the highest level. The Board nomination processes will open this Fall. Check for updates on the RPA website and look for announcements in RPA eNews in the months ahead.

Following the success of the 2025 Las Vegas Annual Meeting, RPA is already developing plans for the 2026 Annual Meeting on April 16-19, 2026, in Atlanta, GA. The RPA Annual Meeting is the premier event in nephrology practice and will continue our tradition of bringing together leading professionals in kidney care while creating unparalleled opportunities for education and networking. The ***2026 RPA Annual Meeting*** will focus on helping nephrology practices and professionals navigate the evolving healthcare landscape while maintaining excellence in patient care. Meeting registration will open in November 2025. Visit the RPA Meetings and Events webpage for updates as they unfold.

RPA public policy efforts help shape legislative and regulatory success for the kidney community. RPA participates in a variety of coalitions and collaborates with cross-disciplinary sister organizations to ensure the issues that matter most to the delivery of high-quality kidney care in service of patients with kidney disease are addressed and supported by experienced professionals with a history and track record of advocacy wins and success. RPA Political Action Committee (PAC) facilitates the ability of RPA to respond to changes affecting nephrology practice that are the result of legislative or regulatory action. RPA advocates for the entire community regardless of your membership affiliation. Whether your focus is academia, research, or clinical practice in all settings, RPA's wins have helped ensure nephrology professionals and patients with kidney disease have an organization fighting daily on your behalf for optimal kidney care for all. Please help us continue our efforts and give to the RPA PAC today!

Speaking of ***membership***, RPA offers opportunities designed to support every stage of your professional career, from early-career to seasoned physicians to advanced practice professionals, practice managers and administrators all shaping nephrology practice and leadership. RPA member benefits are wide-ranging and allow access to cutting-edge and timely content addressing the wide range of emerging challenges in health care, such as: AI integration, value-based care models, telehealth sustainability, operational health and success, policy, regulatory and payment changes and updates, along with practice management tools promoting responsiveness to ever-changing health care trends. As we move toward 2026 and beyond, RPA members will be at the forefront of transforming nephrology practice for the continued evolution of kidney care. RPA members please look out for your membership renewal information in September. If you are not an RPA member yet, I invite you to join the RPA community of leaders today and become part of an organization dedicated to empowering the kidney community through education and advocacy, working toward optimal kidney care for all while building sustainable practices for the future.

The Employed Physician's Responsibility, and How RPA Can Help

Through my recent readings and reporting on physician employment trends, I have been forced to acknowledge the shifting landscape of medicine and how it is affecting physicians. This is obviously a complex multi-layered issue that I may give differing opinions on depending on the day or time when I am asked, and I must believe many of us feel this way. The truth is the majority of physicians signing contracts with large healthcare systems are early in their career. I will readily admit there was not one day or even hour of my ten years of medical training that prepared me to understand the nuances of my employment agreement, the operational structure and motivations of my employer, and the upstream policy decisions that somehow *do* influence the amount of satisfaction or burnout I feel on any given day at work.

This is not meant to be a critique of my medical training, which prepared me well to provide excellent patient care, but is more a recognition of the limitations of our medical education system, and the requirement not only for lifelong learning but for shifting of our education goals throughout our careers. As mentioned previously in this series, I fully believe this (self-taught for most of us) knowledge of the larger policy landscape and healthcare structures is crucial for everyone but often overlooked by those of us who are employed. As physician employment becomes more integrated into the larger healthcare systems, physicians may burnout and shift back toward independent practice or leave healthcare altogether. The alternative, I would argue, is to find a way to thrive where you are, enjoying the benefits of employment while also maintaining independence in your practice. This requires an understanding of the system in which you work and enough influence to mold it to fit ourselves, our colleagues, and our patients.

I can't even begin to forecast the evolving physician employment structures, and how nephrologists will practice in the coming years, but I suspect any solution will require creativity and a lot of advocacy, in addition to an in-depth understanding of the history of health care policy and how we came to where we are now. RPA is well positioned to lead employed physicians in this charge.

Hanna Webb, MD

Nephrology fellows throughout the country are entering the job market every year with no formal education about contracts, pay structures, billing and coding, insurance basics, personal finance, and policy issues. This can clearly be a problem for fellows, but also for the nephrology community at large, as early career physicians may experience job dissatisfaction as a result, hindering future recruitment to the specialty. Setting up "primer courses" for both fellows and new or interested current RPA members could increase involvement in the organization and give many a starting point for advocacy, either within their own organization or on a national level. Any education materials should be inclusive to all and created by a diverse group of RPA members with a wide range of insights.

Outside of the RPA, we can all likely do a better job of asking more questions in our own organizations and even state or local governments. Making our voices and perspectives heard as nephrologists is an invaluable way to move the specialty forward regardless of your practice setting. I firmly believe the more physicians express an understanding in policy and organizational issues, the more likely they are to be "invited to the table" when decisions need to be made.

Dr. Webb is a Assistant Professor of Clinical Medicine at Indiana University School of Medicne and practicing nephrologist at IU Health. She received her undergraduate degree from Michigan State University, studying nutritional sciences and bioethics. She then went to medical school at Indiana University School of Medicine.

Modernizing Nephrology Compensation

Nephrology compensation models made sense when most groups were small and success depended on individual physicians driving hospital consults and dialysis patient volume. Lower starting salaries, often seen as sweat equity, were tolerable because the payoff came later through fee-for-service (FFS) revenue, medical directorships, and ownership.

That world is changing. Practices are larger, care is shifting toward outpatient and population health, and physicians are more mobile and diverse in their expectations. Payment is also moving away from fee-for-service toward value-based care, where revenue depends as much on infrastructure and outcomes as it does on individual effort.

Can our current compensation and buy-in structures keep pace? The answer depends on whether they still deliver stability, fairness, and performance while aligning with where nephrology is headed in your market.

Why Legacy Models Could Fail Us

Legacy structures follow a predictable pattern: Several years of below-market salary, uniform salary and bonus once tenure thresholds are met, and a fixed or nominal buy-in for eventual distributions. These systems created stability when practices were smaller, revenues were dominated by fee-for-service, and loyalty was high.

Now they create friction. Recruitment suffers when fellows see low starting salaries compared to hospital offers. Mid-career hires resist subsidizing senior physicians while earning the same as new graduates. Equal pay models ignore differences in workload, call burden, leadership, and growth efforts. Senior partners hesitate to fund investments in technology, staff, or services if they don't think they'll see a return before they retire.

Buy-ins are another challenge. In many groups, they're structured so low that they undervalue the practice. They don't grow alongside the intangible or unseen investments made in the intellectual property required to be a successful, modern nephrology practice.

Jennifer Huneycutt, CPA, CMPE

The current methods also fail to account for external shifts. Payer dynamics and decline in FFS reimbursement demand infrastructure and analytics that many practices cannot build if they distribute all earnings annually. Value-based care depends on population management, coding accuracy, and transitional care. These concepts aren't currently reflected in most compensation plans.

The issue is not a single failing component. The problem is that compensation and ownership models remain tied to an environment that is diminishing. These weaknesses compound over time. Recruitment becomes harder, culture frays as junior physicians view the system as rigid, while senior physicians hesitate to reinvest. Without building the infrastructure, analytics, and care coordination needed for VBC, practices risk falling behind in both performance and opportunity. Legacy models that once held groups together may now hold them back.

Principles for a Sustainable Model

A sustainable compensation structure must reflect how nephrology practices operate today and where they are headed. Each of these five principles carries equal weight in guiding the design:

Transparency. Compensation, incentives, and profit distributions must connect clearly to practice performance across fee-for-service (FFS) and value-based care (VBC) revenue. Transparency also requires acknowledging two distinct drivers of revenue: Individual physician work and the practice platform. Systems, workflows, reputation, and non-provider services create opportunities that extend beyond any one physician's output. The structure must recognize both contributions without overstating either.

Equity, not equality. Equal pay flattens real differences in workload, call, leadership, and contributions to

growth and VBC outcomes. A fair structure must account for these factors while also considering the group's platform investments, which are the shared systems and support that enable everyone's success. Equity balances recognition for individual effort with shared benefit from organizational resources, while avoiding excessive pay gaps that fracture culture.

Predictable total compensation. Physicians need income stability to plan their lives, but stability cannot come at the expense of responsiveness and adaptability. Compensation should deliver a dependable baseline while allowing variability for individual performance, group results, and shared savings. Predictability also extends to how reinvestment decisions are made, ensuring physicians understand how infrastructure spending today supports future opportunity.

Flexibility. Models must work for physicians at every stage of their career, including fellows, mid-career, and those nearing retirement, and for a workforce that is more diverse than ever. Cultural and gender-driven expectations around workload, scheduling, and income must be reflected. Flexibility also includes the ability to adapt as payer dynamics evolve, so the model remains effective under shifting FFS and VBC mixes.

Balanced use of profit. Distributing all earnings each year may feel rewarding in the short term, but it limits a group's ability to invest in analytics, care coordination, and infrastructure. Profit decisions must be deliberate, with physicians understanding how retained funds strengthen the platform and create future earnings potential. Structuring how ownership shares are valued to make the link between share value and reinvestment clear, aligns physicians on both the short-term and long-term benefits of profit decisions.

Each principle reinforces the others. Together, they create a framework for compensation systems that recruit and retain talent while building practices capable of competing and growing under modern reimbursement structures.

Building a Modern Compensation Framework

Compensation needs to reflect how nephrology practices make money now and how we'll make it in the future. A solid approach blends a steady base salary, a modest productivity component, and quality or VBC incentives. Profit has to be treated as profit, not another layer of pay, so that ownership carries real meaning.

A simple breakdown looks like this:

- **Base salary (60-70%):** The foundation, tied to role, tenure, and core service commitments. Primarily funded by predictable revenue sources such as medical director revenue and FF revenue.
- **Productivity (10-20%):** Recognition for individual effort, measured by RVUs or an internal points system, capped so the gaps between physicians don't get out of hand. Keeps a volume incentive in place without pulling us back into a pure FFS mindset.
- **Quality and VBC incentives (10-20%):** Rewards for work that drives shared savings and bonuses—coding accuracy, transitional care, population health outcomes, and similar measures. Paid from VBC revenue and designed to grow as those streams grow.
- **Profit distributions (separate):** True return on ownership. Groups need to be deliberate about how much profit is distributed versus reinvested, because reinvestment is what builds the platform needed to succeed under hybrid FFS and VBC.

This framework lines up with how revenue comes in, rewards the work that supports both volume and value, and positions a group to grow and stay independent.

Implementation Strategy

Rolling out a new compensation model is as much about process as it is about design. The numbers matter, but what determines success is how the group works through the change together.

Start by making sure physicians understand how the practice earns its money. Many underestimate how much revenue comes from the platform itself, including the systems, staff, and reputation that open doors for contracts and programs, and how much comes directly from individual work. Small-group settings work best for this, giving everyone a chance to ask questions and voice concerns without the discussion turning into a debate.

As the group talks through a new structure, use modeling to help frame the discussion. Show how different weightings for base, productivity, and quality incentives would have performed using your historical results. Model scenarios for different physician profiles, including growth-focused, sustaining, junior, senior, part-time, and full-time so everyone can see how the

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Marketing Hyponatremia

Sitting at the table, my teacher casually asked, "What is hyponatremia?"

My resident answered, "Low sodium."

She playfully tossed a piece of chalk at him and said, "Try again."

We laughed sheepishly. He corrected himself: "Too much water."

Few words in medicine generate as much confusion as hyponatremia—and not among patients. Even clinicians stumble. It's a term that sounds deceptively simple but is often misunderstood. Like inflammable, restive, or nonplussed, it belongs to that category of words whose meanings often confound rather than clarify.

Hyponatremia is, by construction, a mashup of Greek and Latin: Hypo- (Greek for "low") and natrium (Latin for sodium, hence Na^+). But the real issue isn't etymology—it's branding. Renal medicine has always struggled with its image. Nephrology is often viewed as cerebral, complex, and opaque. In some circles, nephrologists are revered as the smartest people in the room. The specialty is deeply physiologic, highly technical, and filled with nuance. But in the broader worlds of healthcare, policy, and patient care, being the smartest doesn't win hearts—or change behavior. Being understood does.

Of course, not all of us have had the benefit of being pelted with chalk to drive a point home (and let's be honest—neither our patients nor our colleagues would appreciate it). But we do carry a responsibility: To communicate nephrology in ways that are clear, compelling, and memorable. Over time, I've experimented with different ways to teach hyponatremia—to both students and patients. I've tested countless metaphors to see which ones spark true understanding—and, ideally, change behavior. Each encounter has become an opportunity to refine my approach and gather real-time feedback.

Elizabeth Kurtz, MD

I begin with a hook. I used to describe hyponatremia as "too much water," but found it did not generate immediate recognition or concern. Eventually, I shifted to calling it water intoxication. Words matter. Intoxication carries emotional weight—it evokes danger, loss of control, and impairment. It creates a sense that something is wrong and must be fixed. To resolve the tension between salt and water, I turn to a visual metaphor: I ask patients to imagine their body as a bowl of chicken soup. Add enough water, and the soup tastes less salty. That's hyponatremia—the salt is diluted by too much water. This metaphor consistently generates curiosity and questions.

One piece of advice I've often received from mentors is: Learn how to market yourself. But increasingly, I find myself asking: How do we market nephrology? How do we make it a "sexy" field—one that captures attention, invites curiosity, and is easy to grasp? Is it time we borrow strategies from marketing, product psychology, and behavioral economics? Should we present nephrology the way influencers promote brands—or the way the wellness industry sells transformation? If we want people to care about kidneys and change their habits, maybe it's time to reframe the narrative entirely—and focus on the power of presentation.

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 Teredesai, McCann & Associates, P.C. in Pittsburgh, PA, in 2022.

Despite Election Off-Year, the Work of the RPA PAC Continues

In the U. S. election cycle, the year following a presidential election is probably the quietest regarding political fundraising. Next year of course will be the mid-term elections, and the year between the mid-terms and a presidential election is usually highly active on the campaign front, with the year a president gets elected being the most intense.

This is not to say that off year elections are meaningless. While there are no federal offices on the slate this year, there will be statewide elections in New Jersey and Virginia, and although in New Jersey the current Democratic control of the governor's house and legislature is expected to continue, Virginia is a different story. The current Republican governor, Glenn Youngkin, is term limited, and in the race to succeed him, the Democratic candidate, Abigail Spanberger (a former member of the U. S. House) leads the Republican candidate Winsome Earle-Sears (the current Lieutenant Governor) by double digits, according to a July poll from Virginia Commonwealth University. Off-year elections can sometimes be significant as an indicator of national mood or a reflection of public opinion on the first year of a presidential term, but in the present political climate drawing too many conclusions from polling is foolish.

Moving back to the federal side, events supported by the RPA PAC have been limited thus far in 2025, although the pace should pick up in the fall. In March we supported events for the two Congressional Kidney Caucus (CKC) Co-Chairs, Reps. Suzan DelBene (D-WA), and Carol Miller (R-WV), both members of the House Ways and Means Health Subcommittee. In their roles as CKC Co-Chairs Reps. DelBene and Miller are leading the effort to introduce the Expanding Support for Living Donors Act, which would provide more support to living organ donors and address the increasingly high costs of donation by removing financial barriers that prevent many people from donating and combines several elements from the various living organ donor bills out there from last Congress.

Of course, the highlight of the period was the appearance of Rep. Dina Titus (D-NV) at the RPA PAC Reception (as well as at Puppy Playtime; it turns out that Congresswoman Titus is a serious animal rights activist). More significantly, despite not being on a committee jurisdiction for Medicare, Rep Titus demonstrated deep familiarity with issues affecting physician practice and was an early cosponsor of H.R. 879—the Medicare Patient Access and Practice Stabilization Act of 2025, which would address shortfalls in physician reimbursement by tying it to the Medicare Economic Index (MEI) and thus providing an annual inflation update.

As for planned events later in 2025, these include interactions with Rep. Terri Sewell (D-AL, a longtime supporter of the kidney community and member of the House Ways and Means Health Subcommittee), Rep. John Joyce (R-PA, a physician and member of the Energy and Commerce Health Subcommittee), Sen. Ben Ray Lujan (D-NM, member of the Senate Committee on Health, Education, Labor and Pensions), and Sen. Marsha Blackburn (R-TN, and supporter of kidney community priorities in the past and is a member of the Senate Finance Health Subcommittee).

Facilitation of these and similar activities are why the RPA PAC exists. Face-to-face connections with legislators in a position to advance RPA's legislative priorities and other issues of consequence have been and continue to be key ingredients in RPA's policy successes over the years. These efforts cannot

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.

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 may contact the RPA PAC Treasurer, Mary Orgler, at **morgler@renalmd.org**.

As always, 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.

Practice Management *continued from page 16*

structure behaves in a variety of situations. These exercises are not about locking in exact numbers. They help the group see trade-offs and understand how the structure would respond as the mix of FFS and VBC changes alongside other revenue streams.

Keep the timeline predictable and straightforward. Tying the rollout to a fiscal year avoids tax and accounting issues and gives physicians time to plan.

Most of all, communicate why the change matters. A modern compensation structure is not about fixing a spreadsheet. It is about keeping the practice strong enough to recruit, grow, and perform as the payment environment shifts. When everyone sees the reasoning and has a voice in the process, the path forward becomes much clearer.

Final Thoughts

Compensation structures built for smaller, hospital-focused practices in a fee-for-service world are reaching their limits. Nephrology is evolving, with larger groups, a broader mix of physicians, and an accelerating shift toward value-based care.

Updating how we pay physicians is not about fairness. It is about building practices that can recruit, retain, and perform in a changing environment. A model that balances stability, recognizes contribution, reflects the value of the practice platform, and treats profit as profit will position groups to grow and remain independent.

Change does not have to be rushed, but it cannot be ignored. Practices that start the conversation now, and approach the transition deliberately will be better prepared for what comes next.

Jennifer Huneycutt, CPA, CMPE is the Executive Director of Metrolina Nephrology Associates, where she helps lead a team of 80 providers and 180 employees. Her work extends beyond the practice, supporting nephrology professionals through ClearEdge Medical Management, a consultancy firm based in Charlotte, North Carolina, and as a founder of Interactive Nephrology, an online platform dedicated to professional development in the field.

CMS Launches WISeR Model: A Technology-Enabled Effort to Reduce Wasteful Medicare Spending

Nesko Radovic, Scott Downing, Jason Greis, Jake Cilek, Chris DeGrande, Nick Adamson

On June 27, 2025, the Centers for Medicare & Medicaid Services ("CMS"), through its Innovation Center ("CMMI"), released the Request for Applications ("RFA") for a new payment and service delivery initiative: The Wasteful and Inappropriate Service Reduction (WISeR) Model. This six-year demonstration project will test whether the use of advanced technology, particularly artificial intelligence ("AI") and machine learning ("ML"), can support CMS in identifying and reducing unnecessary spending on services provided to Medicare fee-for-service beneficiaries. Applications were due by July 25, 2025, and selected participants will begin operations on **January 1, 2026**, with the model running through **December 31, 2031**.

Two key takeaways from the WISeR Model are: (1) participating technology vendors will be eligible for performance-based compensation through a shared savings methodology, with payments based on cost reductions as determined by CMS; and (2) participation is voluntary for healthcare providers, who may choose whether to engage with the model's prior authorization process or continue under existing post-payment review protocols. Further details regarding both the payment methodology and provider participation are outlined below

Background and Policy Rationale

The WISeR Model represents CMS's latest attempt to reduce waste, fraud, and abuse in Original Medicare by introducing a structured, technology-enabled prior authorization process. Unlike traditional CMS models that primarily target providers, WISeR is structured to test whether private-sector vendors—specifically, technology companies with prior authorization infrastructure—can act as intermediaries in identifying potentially unnecessary or non-compliant care.

CMS estimates that a significant portion of Medicare expenditures—over $5 billion annually—may be tied to services that are either unsupported by clinical evidence or misused in routine practice. Through the WISeR Model, CMS seeks to channel private-sector innovation to improve claims accuracy and safeguard the Medicare Trust Fund.

Model Design and Scope

WISeR will be implemented in four Medicare Administrative Contractor ("MAC") jurisdictions—JH, JL, JF, and J15—which collectively include Texas, Arizona, Oklahoma, Ohio, New Jersey, and Washington. CMS selected these jurisdictions based on a combination of claims volume, regional administrative readiness, and prior program integrity efforts.

A key innovation in the WISeR Model is the introduction of a new class of participant: Technology vendors that will serve as prior authorization entities. These vendors will use AI/ML-assisted tools to conduct an initial triage of prior authorization requests, subject to final review by licensed clinicians. Participants must integrate their systems with MACs and CMS to ensure secure, real-time data exchange and compliance with program standards.

Unlike past CMS efforts that implemented blanket prior authorization requirements through the MACs, WISeR aims to test whether a private-sector, technology-enabled model can support a more targeted and scalable approach. The model will run for six years and is intended to inform future CMS efforts in fee-for-service utilization oversight.

Eligible Participants and Application Requirements

The RFA identifies eligible applicants as entities with prior authorization experience—particularly with Medicare Advantage or commercial insurers—that can demonstrate the following capabilities:

- A functioning, scalable platform that incorporates AI/ML technology to assist in initial review determinations;
- Systems and infrastructure that meet CMS's stringent security and interoperability standards, including HIPAA compliance and FedRAMP certification;
- A panel of licensed clinicians who will provide oversight and final determinations for non-affirmed requests;
- A track record of successful collaboration with health plans or providers on utilization management or similar functions.

Applicants must also be able to accommodate unlimited resubmissions and offer real-time peer-to-peer review mechanisms to allow provider engagement on adverse determinations. CMS has emphasized that participants must maintain transparency, neutrality, and accessibility to avoid any real or perceived conflicts of interest.

The application process will be competitive. CMS expects to select only a small number of participants for the initial performance period. Applications were due to the CMS Innovation Center portal portal by July 25.

Services Subject to Review

The WISeR Model will initially target a defined set of services that CMS has historically associated with high rates of improper use. These include various neurostimulation devices (such as vagus nerve stimulators and phrenic nerve stimulators), skin substitutes used in wound care, epidural steroid injections (excluding injections targeting spinal facet joints), and certain orthopedic procedures, such as knee arthroscopy for osteoarthritis. These services were selected based on CMS data indicating elevated utilization and payment concerns, and all remain covered by Medicare subject to applicable coverage criteria.

Notably, CMS has excluded emergency services and inpatient-only procedures from the model to avoid any delays in care that could compromise patient safety. CMS will maintain existing coverage policies for all services, meaning that WISeR will not change what is covered by Medicare—only the timing and method of review.

Payment and Performance Metrics

Rather than relying on a fixed fee structure, WISeR will operate under a shared savings model. Participating technology vendors will be eligible to receive performance-based payments that reflect a percentage of the cost savings CMS attributes to their review activities. These payments will be risk-adjusted and contingent on a variety of metrics, including:

- Accuracy and consistency of determinations;
- Timeliness of responses;
- Provider and beneficiary satisfaction;
- Impact on downstream healthcare utilization (e.g., reduced ER visits or avoidable admissions).

Participants will also be subject to robust monitoring and auditing by CMS, including real-time data reporting, process evaluations, and corrective action protocols where necessary. CMS reserves the right to withhold or recover payments if a participant fails to meet performance thresholds.

Provider Impact and Strategic Considerations

For providers, participation in the WISeR Model is voluntary, but not without consequence. Providers in the selected states retain the ability to bypass the model entirely and continue submitting claims through traditional channels, subject to standard post-payment medical review. However, CMS has signaled that providers who voluntarily engage with WISeR participants may benefit from more efficient claim determinations, fewer downstream audits, and the potential for "gold card" status—exempting them from prior authorization requirements for certain services if their submissions consistently meet coverage criteria.

In contrast, providers with low affirmation rates or inconsistent documentation may see an increase in scrutiny under existing MAC review protocols. As such, even non-participating providers operating in affected jurisdictions may feel downstream pressure to align

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Telehealth/TH and the MCP/AKI Physician Billing

Question: Will I still be able to bill for remote services provided via telehealth for the rest of the year?

Answer: The situation regarding telehealth at press time is that the current flexibilities—which have been in place since the spring of 2020—are scheduled to lapse on September 30, 2025. However, since the flexibilities were implemented, they have come close to lapsing previously and never have, indicative of Congress' commitment to maintain telehealth availability in health care delivery. That said, the House and Senate will have to pass a bill to keep the flexibilities in place as of October 1. RPA will report on any changes regarding the status of the telehealth flexibilities as they occur.

Question: Hello, I have a question regarding dialysis charges. Our physician sees the patient in the unit as well as by telehealth visits. I am getting denials when insurance companies ask for the medical records and they see that the patient was see by telehealth and I did not put the modifier on the billing. The patient was seen both in person and by telehealth, and my question is would I still put the 95 modifier on the claim? This is a bit confusing to me, it looks like they would still deny either way.

Answer: If the complete assessment/comprehensive visit for the month was completed by telehealth you will need to use either place of service (POS) code 02 (for 'Telehealth Provided Other than in Patient's Home') or POS 10 (for 'Telehealth Provided in Patient's Home'), depending on the location of the patient, and modifier 95 for CPT codes 90960-90962/90966. If only the basic/ limited visits were performed via telehealth, you will bill the MCP code and POS 65 (ESRD facility). Please be advised some commercial and Medicare replacement plans have different rules and may no longer cover MCP services as telehealth.

Question: We have nurse practitioners (NPs) who round at dialysis units. Physicians typically perform the comprehensive visits and the Patient Care Meeting/Quality Assurance and Improvement (QAI) activity. If a physician misses a patient, can the NP perform and bill for a comprehensive visit?

Answer: Yes, if the NP performs the comprehensive visit the MCP charge can be billed under their National Provider Identifier (NPI) and be reimbursed at 85% of Medicare the allowable physician rate.

Question: I have a question regarding billing for peritoneal dialysis (PD) training. Are these able to be completed via telehealth?

Answer: No, PD training services are not approved for telehealth services. The complete list of Medicare approved telehealth codes for 2025 is available at https://www.cms.gov/medicare/coverage/telehealth/list-services, with the list for 2026 from the proposed rule not yet finalized.

Question: Can you please advise on nephrology coding and required documentation for 90945 and 90935? Information found on CMS (from 2003) that the "physician must have been physically present with the patient at some time during the course of the dialysis." and the documentation should reflect this. This has always been my understanding for 90935-hemodialysis, but I had not previously heard this for 90945–PD or CRRT.

Answer: For PD and continuous renal replacement therapy (CRRT) it is best practice that the nephrologist see the patient while on dialysis, like other forms of inpatient dialysis. However, CPT code 90945 can still be billed when the patient is off dialysis (as the therapy is understood to be continuous throughout the entire day). For example, a patient might be on the cycler for PD at night and the nephrologist sees the patient in the day. For CRRT, the machine might be interrupted for a clotted circuit or when the patient goes for a procedure or imaging study. RPA recommends documenting that the provider is managing the dialysis therapy and include some details about the prescription (such as the number and volume of exchanges per day) and add a short statement about how the patient is tolerating therapy.

Question: What CPT code(s) would the professional providers bill for home PD dialysis for patients with AKI? Is there any regulations or guidance that you can direct us for reference?

Answer: Currently, there is no formal CMS or AMA guidance specific to professional billing in this scenario. That said, for professional billing of home PD for AKI, we recommend using CPT 90945 when the patient is seen at the dialysis unit, as E&M codes with POS 65 are often denied. If the patient is seen outside the unit (e. g., office or by telehealth), standard E&M codes (such as CPT code 99214) should be used with the appropriate POS. MCP codes (90951-90970) are not billable for AKI. Given that these are acutely ill patients, RPA's expectation is that use of home dialysis to treat AKI patients, especially by telehealth, will be relatively rare.

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.*

Legal Column *continued from page 21*

their documentation practices with the standards applied through WISeR.

Healthcare organizations should carefully evaluate the operational implications of WISeR, including the compatibility of their existing workflows with the technology platforms selected by participating vendors. Early engagement with those vendors may help providers avoid disruption and capitalize on any administrative efficiencies the model may offer.

View the WiseR Model CMMI webpage, which includes the RFA and FAQs.

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.*

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Our 2025 road trip will wrap at the RPA Advocacy and Innovation Weekend on October 10-11, 2025 in Washington, DC. Learn more and register at www.renalmd.org. If we did not make it to your city in 2025, **THE ADVENTURE ISN'T OVER!** We will be back "On the Road" in 2026!

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