

RPA News

May 2020
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**The Advocate
for Excellence in
Nephrology Practice**

What a Difference a Year Makes

The last 12 months have been monumental for the kidney care community with the announcement of the Advancing American Kidney Health Initiative (AAKH) by President Trump last summer and the subsequent development and release of several new kidney payment models by the Centers for Medicare and Medicaid Innovation (CMMI). RPA has had a front seat to all of these exciting changes and has been working closely with the Administration and relevant agency staff to influence the new models so that nephrology practices are able to participate in a way that enables them to improve kidney patient care and succeed financially. RPA President Dr. Jeffrey Perlmutter intended to review the highlights of RPA's activities related to the roll out of the AAKH as well as in other areas over the past year during his address at the RPA Annual Meeting. Since that meeting was cancelled, a summary of key RPA activities over the past year is provided below.

Following RPA's 2019 Annual Meeting, the association launched RPA CONNECT, an online member engagement communication platform where nephrology professionals can share ideas, ask questions, and discuss issues of concern. You can join one or more of the communities on the platform, from medical directors to practice administrators to early career physicians, among others. There have also been several online discussion forums moderated by experts in the selected topics. During the past year, these discussions addressed Utilizing Telehealth to Manage Patients Receiving Dialysis Care; Uncompensated Kidney Care in the United States — Who Pays?; Pain Management in Kidney Care; and Best Practices for CKD Management. The latest topic, which is live now, focuses on the Lifecycle

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RPA Creates COVID-19 HUB

To assist nephrology professionals with easily accessing practice resources related to operations and kidney care delivery during the coronavirus public health emergency, RPA created a central place for RPA guidance, Congressional correspondence, Federal guidance, AMA resources and patient education tools to help you care for yourself, your practice, and your patients during this challenging time. This portal is accessible from the RPA homepage at [renalmd.org](https://www.renalmd.org) and will be frequently updated. A list of the items included in the HUB as of April 1 is provided below.

RPA GUIDANCE

RPA Guidance on Billing and Coding for Remote Nephrology Services
New CPT Code Announced for NOVEL CORONAVIRUS Testing

REQUESTS FOR CONGRESSIONAL RELIEF

ASPN and RPA ESRD Letter to Congressional Leaders
Alliance Telehealth Waiver
AMA Sign-on Letter

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From Capitol Hill

Congress Amidst COVID-19

By Robert Blaser, RPA Director of Public Policy

Usually this column begins with a light-hearted anecdote or recollection about sports, pop culture, or *Life in These United States* (h/t Reader's Digest) that is informed by my late boomer sensibilities. One way or another, some connection that I delude myself into thinking is clever gets made to what is going on in Congress, and off we go.

Unfortunately, there's nothing light-hearted or whimsical about our situation right now. A pandemic, the likes of which has not been seen for at least over 100 years, if not longer, the resulting economic catastrophe, strains on the health care infrastructure that in many situations are beyond the breaking point, and a cessation of normal daily activities have taken global, national, local, and personal tolls. These are immensely challenging times.

For its part, Congress has stepped up in some key ways. There have been a series of (at press time) three stimulus bills passed, the first and third of which made some changes of great relevance to physician practice broadly, and nephrology specifically. This began on March 6, when Congress passed the first of its COVID-related bills, the Families First Coronavirus Response Act (H.R. 6201), which included language directing the Secretary of Health and Human Services (HHS) and CMS to waive constraints on the use of telehealth related to originating sites and geographic restrictions (among other things, of course). CMS acted on this direction on March 17, advancing the widespread use of telehealth in response to the pandemic.

Subsequently, on March 27, the Coronavirus Aid, Relief and Economic Security (CARES) Act (H.R. 748) passed the House of Representatives by a voice vote after previous passage by the Senate and was signed that day by the President. The \$2 trillion legislation

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Options for Virtual Advocacy: Hill Day • PAC • PAL

See pages 5, 12, 15

President's Message



Jeffrey Perlmutter, MD
RPA President

During the RPA Annual Meeting, it has been our tradition for the current president to present the RPA Year in Review. Well before we had to cancel the meeting, I had decided to break with that tradition and to instead focus my presentation to the attendees as a state of the profession address as it pertains to the RPA (a SOTP from the POTRPA). I believe that most of the attendees are aware of RPA’s work and that they could read about highlights from the past year in the newsletter that is distributed at the meeting. (see article on page 1 for a summary of the past year’s activities.) Also, I felt that the seminal, generational changes that our specialty was about to undergo warranted more than a recital of the accomplishments of the past year. As of Tuesday, March 10, I had been hopeful that we would be able to hold the meeting. By Thursday the 12th I knew that we could not proceed. In my address I had planned to tout the accomplishments of the RPA not just in the past year but in our nearly 46-year history. I was going to discuss the challenges facing the nephrology workforce and was going to summon the attendees to meet that challenge. History intervened, and now I feel more introspective than inspirational.

In October of last year, RPA leadership and selected stakeholders completed our triennial strategic plan. We created new vision and mission statements which can be found in the Year in Review article which we have included in this publication. We view the RPA as “Championing Excellence in Kidney Care and Forging the Future for the Nephrology Profession.” For now, it will have to suffice for us to succeed in the present to provide care to our patients and to keep people, including ourselves, safe and our practices viable. By the time you read this, RPA will have provided guidance on the use of telehealth and hosted a webinar on providing care for our patients during the viral pandemic.

In order to prepare for my address at the meeting, I had reviewed, not for the first time, the book we published to commemorate the 40th anniversary of the RPA. I reviewed the list of past presidents contained within and those more recent and felt honored and humbled to be included among them. I was proud of the past accomplishments of the RPA, as I am sure I will continue to be impressed by our future achievements. Our past successes illustrate what we consider to be our present core competencies: being the voice of nephrology, supporting the business of nephrology, leading and learning in nephrology and supporting the community of nephrology.

I missed the comradery and the learning opportunities provided at the Annual Meeting, not just from the speakers but also from my fellow attendees. I finished reading “Organized Medicine” by our invited Lou Diamond lecturer, Sharon Kaufman. Her book contains specific emphasis on the issues of dialysis and transplantation that are provocative, and it would have been important for us to have been able to question her. Maybe she will be able to join us at a future meeting. More directly related to our practice operations, we missed

the opportunity to learn about and debate the CMS-proposed mandatory and voluntary care delivery models about which my prior messages to you were focused.

In a way, the outbreak of SARS-CoV-2 is putting to the test some of the tools we were going to need to be successful in caring for our patients in the new care paradigm. Rapidly, we are learning to use telehealth to care for our patients in a time of social distancing. This will be an important way to limit in person visits in the KCF and CKCC models. Last week, I did all my office hours and home dialysis visits via remote communication from outside my office. There are ways, too, to round in dialysis centers without a physical presence, though I have chosen, taking great care, to continue in person dialysis rounds for my in-center patients. Except in rare instances, I have given up my stethoscope to be able to maintain as safe a distance as possible. I am grateful that we have been given the leeway to adjust the way we deliver care, and commend CMS and other governmental agencies for having allowed us to do so. I hope that what we learn from this can help convince the legislative and regulatory authorities that some of this needs to continue. There is no reason that a debilitated patient has to schlep to my office for a visit even if there is not a risk of viral transmission. Perhaps we can convince the payers that the pointless adherence to documentation criteria can be dispensed. EHRs have made a mockery of this anyway. After all, they do want us to put “Patients over Paperwork.”

For the first time in my not short medical career, I have been fitted for a N95 respirator mask (because of my goatee I have to use a “duckbill” one). This means that in the rare past instances when a N95 was required, I was wearing one that did not fit properly. After my fitting, I was given the mask in a plastic bag and told to hang onto it as it might be the only one I get. Though I understand full well the shortages we face in protective equipment, this brought it to a very personal level. I recognize we are all under tremendous stress. I worry about the nurses and everyone who provides direct care to patients. I worry about our patients who have always been among the most vulnerable and about other at-risk members of the community. I worry about my family. My office staff were worried about seeing me because I am on the front lines in the medical world (we have now gone to a completely virtual office except to pick up mail and other paperwork). I find myself cheering semi-trailers on the highway and I think about all the people who do the mundane but essential jobs that allow us to do ours.

Because of travel advisories, the PREZMOBILE has been limited to local travel only. I look forward to seeing all of you, but will not venture to predict when that will be. I can only hope that it will be as soon as possible and that we find each other well. ■

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Editor's Expressions



Dale Singer, MHA
RPA Executive Director

Normally in this column in the May issue of this newsletter I highlight specific events that occurred at the annual meeting that set the tone for the coming year. RPA's annual meeting energizes members of the nephrology community as well as RPA staff and is the culmination of nearly one year's worth of work planning relevant and timely program topics, identifying the best speakers, and providing opportunities to maximize engagement and dialogue. This is the first time in RPA's 46-year history that external events forced us to cancel our annual meeting and all ancillary events.

As you might imagine, in the final weeks leading up to the March 19-22 meeting that was to be held in Baltimore, news of the coronavirus spreading and measures to contain it increased exponentially. We waited to cancel the meeting until we learned that it would be illegal and impossible to hold this meeting after the Maryland Governor banned all gatherings of more than 250 people (several days later he reduced that number to 50 people). Personally, the decision to cancel the meeting was obvious; however, it was also devastating. The RPA leadership and staff considered all of our options but ultimately decided that it made the most sense to expand the content delivered at the PAL Forum in June (assuming we will be able to host that event) and offer webinars in the coming months with many of the speakers who prepared outstanding presentations for the annual meeting.

In the weeks leading up to the decision to cancel the meeting, I experienced the five stages of grief famously described by Elisabeth Kubler-Ross. Initially, I was in **denial** that RPA would need to cancel our meeting. After all, we do not have any international attendees and we usually convene no more than 600 people. Early guidance regarding COVID-19 indicated that there were concerns regarding international travel and large gatherings defined as more than 1,000 people. I then moved to the second stage of grief and was **angry** when domestic travel began being impacted and social distancing became part of our culture, further limiting the numbers of people who could gather together. I was angry that this external virus that was outside our control was having a huge impact on our society, and specifically, our association. I moved to the **bargaining** stage as speakers began to cancel when their employers banned domestic travel and we started to make provisions for live streaming their talks to keep the integrity of the meeting content whole. But then I quickly became **depressed** when I realized that our country was shutting down and there was no way RPA could proceed with bringing together health professionals where they could risk exposure to the coronavirus. This became impossible when the Maryland governor forbade gatherings of more than 250 people. The control and the choice were taken out of our hands. As the staff began the process of notifying all registrants, vendors, sponsors, exhibitors and speakers that the RPA 2020 Meeting was cancelled one week prior to its scheduled occurrence, I moved into damage control. At this point I **accepted** our fate and began to think through how to answer a series of questions.

How do we lead in times of crisis? How could we minimize the financial impact of the cancellation on RPA? What options did we have to share valuable content with nephrology professionals? How could we keep members engaged in the association until our next large face-to-face gathering at the 2021 Annual Meeting in New Orleans?

We hit the pause button and considered all of the variables. Even though the conference venue waived the enormous cancellation fee due to the governor's Order, RPA incurred significant expenses promoting

the conference and working with audiovisual and exhibit vendors to prepare for the conference. We will not be able to recoup those sunk costs. In addition, we had budgeted a net profit from the annual meeting, leadership workshop and coding seminar to offset other RPA program expenses that are incurred throughout the year. We greatly appreciate the generosity of those registrants who donated their fees back to the association to help mitigate some of the sunk costs. In addition, several exhibitors offered to apply their fees to their participation in the 2021 Annual Meeting, where they will receive the first opportunity to select the location of their booths. However, the loss of revenue coupled with the expenses incurred will affect association operations for the remainder of the year.

Your support of RPA is needed now more than ever. While we understand that you have had enormous challenges during the pandemic as health care professionals on the front lines taking care of an at risk population, RPA wants to be able to continue to provide you with the tools, resources and services that are essential to your survival in practice. The majority of contributions to our Political Action Committee (PAC) are received during our annual meeting. Please consider supporting the PAC and sending a check or donating online to enable us to continue our strong advocacy efforts on your behalf. (See article on page 16) If you have not yet renewed your membership for 2020, please do so at your earliest convenience. RPA staff and leaders have been working tirelessly to waive limitations on the provision of telehealth and ensure that essential procedures needed by kidney patients are deemed essential. For up to the minute resources, please check our COVID-19 HUB at www.renalmd.org.

David Kessler, an expert on grief and the coauthor with Dr. Kübler-Ross of *On Grief and Grieving*, added a sixth stage to the grieving process: **meaning**. During this phase, we determine how to move forward in a way that honors our loved ones, and, in RPA's case, makes the most of RPA's conference cancellation.

We have taken this opportunity to expand our elearning content by working with several annual meeting speakers to present webinars, and are building out our PAL Forum content to add relevant sessions specifically on policy, advocacy and leadership to that event in June in Washington, D.C. (see article on page 15) While we missed the opportunity to engage in thoughtful conversations with nephrology practitioners from around the country as well as RPA's industry supporters during the annual meeting, I hope you will take advantage of **RPACONNECT.renalmd.org** to engage with your colleagues online to discuss how they are dealing with the coronavirus, among other challenges.

At press time, it remains uncertain how long restrictions will be in place to stave off the spread of COVID-19 and how it will continue to affect our way of life. Fortunately, the RPA staff can work remotely to continue to serve nephrology professionals at a time when you need to lean on your professional society the most. Our Board of Directors and committees are working remotely too, so that projects may move forward and decision-making progresses. We look forward to engaging with you face-to-face as soon as it safe to do so, hopefully during our Capitol Hill Day and PAL Forum June 26-28. Thank you for your continued support of RPA, now more than ever. ■

COVID-19 HUB

from page 1

AMA RESOURCES

AMA Summary of CARES Act
The AMA COVID Resource Center
AMA's Role in COVID
AMA Coding Advice

PATIENT-EDUCATION RESOURCES

Communication Strategies During a Pandemic

CMS RESOURCES

ESRD Provider Telehealth and Telemedicine Toolkit

FEDERAL GUIDANCE

OIG COVID Cost Sharing Policy on Telehealth
CMS Fact Sheet on Accelerated and Advance Payments for Medicare Providers
State Section 1135 Waivers

PEER REVIEWED LITERATURE

Mitigating COVID-19 in Dialysis Facilities

What A Diference a Year Makes

from page 1

of a Nephrology Practice. Engage with your colleagues at <https://rpaconnect.renald.org/pages/home>.

Five years ago, RPA launched its Kidney Quality Improvement Registry (RPA Registry) to assist nephrologists with fulfilling reporting requirements outlined in the Centers for Medicare and Medicaid Services (CMS) Quality Payment Program and conduct benchmarking and performance gap analysis to improve kidney care. Once again, CMS has granted approval to the RPA Registry as a Qualified Clinical Data Registry (QCDR) for 2020. In addition, hundreds of nephrologists obtain maintenance of certification (MOC) credits annually from the American Board of Internal Medicine (ABIM) for participation in the Quality Assessment and Performance Improvement (QAPI) program through utilization of the RPA Registry. Over the past year, RPA received two grants from industry to use this registry to conduct research. The results from the first project, which focused on the impact of hyperkalemia on chronic kidney disease (CKD), will be published in a peer reviewed article in the coming months. The second project is gearing up and will focus on examining bone metabolism disorders in people with CKD.

Much of our work in the advocacy arena over the last year focused on shaping the payment models proposed by CMMI. RPA submitted comments on the proposed rule outlining the mandatory End-Stage Renal Disease (ESRD) Treatment Choices (ETC) Payment Model—the final rule has been delayed with an implementation date uncertain at press time. At the end of October, CMMI released the long awaited RFAs for the voluntary payment models. RPA focused its attention on the Kidney Care First (KCF) model. RPA believes the KCF should be accessible to as many nephrology practices as possible, and developed guidance for our members to consider the benefits and challenges of participation before deciding to submit an application ahead of the January 22 due date. RPA also provided feedback to CMMI on several of the provisions outlined in the model, including alternate quality measures that may be better suited for tracking and reporting by nephrology practices. At press time, RPA is planning to hold the sessions about the AAKH and the payment models that were planned for the annual meeting during the PAL Forum in June. CMMI has put these models on the back burner for now, in light of the coronavirus pandemic and its effects on physician practices.

As a result of your support, RPA had several significant successes in the advocacy arena over the past year:

- **Maintained Appropriate Reimbursement for Vascular Access Services in ASCs**
In recent years, CMS has proposed and/or finalized changes in reimbursement for outpatient dialysis vascular access care that have threatened patient access to those services. For 2019, the Agency proposed cuts of 55 percent and 54 percent for the two high volume balloon angioplasty services (CPT codes 36902 and 36905) when provided in the Ambulatory Surgical Center setting.

RPA not only led the effort to dissuade CMS from finalizing this proposal for 2019, but our ongoing advocacy resulted in CMS deciding to not even propose those changes for 2020.
- **Secured Introduction of Immunosuppressive Drug Coverage Legislation**
In late December, HR 5534, the Comprehensive Immunosuppressive Drug Coverage for Kidney Transplant Patients Act, was introduced in the U.S. House of Representatives. In late February the Senate version of the bill was introduced (S. 3353). Extension of immunosuppressive drug coverage for the life of the transplanted kidney has been a legislative priority for RPA for over ten years.
- **Reduced Impact of Revision and Revaluation of Medicare E&M Service Codes on Nephrology**
As the nephrology specialty’s representative to the AMA’s CPT Editorial Panel and Relative Value Update Committee (RUC), RPA helped develop an alternate methodology to the 2018 CMS proposal to compress payment levels for all outpatient evaluation and management (E&M) services to a single level for each family. This process resulted in proposals adopted by CMS for implementation in 2021.

- **Obtained Payment for TCM Services to ESRD Patients**
RPA’s advocacy efforts resulted in CMS removing the prohibition against billing transitional care management (TCM) services in conjunction with the monthly capitation suite of outpatient services provided to ESRD patients. This allows nephrologists to more appropriately manage the care provided to ESRD patients who have recently been discharged from the hospital and get reimbursed for those services utilizing the TCM codes. RPA also advocated for the dialysis facility to be an allowable site of service for these claims.
- **Attained Transplant Bonus in Kidney Payment Models**
RPA urged senior staff from CMMI to include a sizable bonus for successful kidney transplants for beneficiaries aligned with nephrology practices in the kidney payment models developed by CMMI. RPA included this bonus in RPA’s original ESRD Clinical Episode Payment Model proposal to the Physician Payment Model Technical Advisory Committee (PTAC).

A transplant bonus of up to \$15,000 over three years was ultimately included in the voluntary payment models developed by CMS and released in 2019 due to RPA’s advocacy efforts.

Please contribute to the RPA PAC and participate in Capitol Hill Day on June 26 in Washington, D.C. so that we can continue to have future advocacy successes. Your support is crucial to the future of legislation and regulations affecting kidney care and the nephrology profession.

Last October, the RPA Board, along with several invited guests representing diverse stakeholder groups, met to craft a strategic plan to focus the association’s activities for the next two to three years. Our efforts resulted in the creation of a new vision:

Championing excellence in kidney care and forging the future for the nephrology profession.

We also developed a new mission statement.

- RPA empowers nephrology professionals through:
- Leadership development and mentorship
 - Regulatory and legislative advocacy
 - Development and promotion of best business and care delivery practices

Our goals address four areas that highlight RPA’s core competencies:

- The Voice of Nephrology
- The Business of Nephrology
- Leading and Learning in Nephrology
- Community of Nephrology

For each of the goals, we developed strategies and focused tactics to help us achieve success. Unfortunately, the coronavirus pandemic has impacted association operations, so there may be a delay in proceeding with strategic plan implementation. Due to the rapidly changing demands imposed by the pandemic, the staff and leadership have shifted priorities to remove regulatory and legislative barriers that would hinder nephrology professionals in delivering high quality, safe kidney care and receiving appropriate compensation for telehealth and other services. We marshalled resources quickly to develop the COVID-19 HUB on the RPA website to house guidance, tools and resources for nephrology professionals. More than 600 people participated in RPA’s webinar on telehealth in early April, where up to the minute information was presented and questions were answered to assist nephrologists with how to provide and get paid for care to kidney patients during the coronavirus pandemic. The recorded webinar, slides and Q and A Document are posted in the COVID HUB on the RPA website.

RPA’s nimbleness and expertise enables the association to adjust priorities and rapidly respond to external influences that impact kidney care and the future of the specialty. Rest assured that your professional society will continue to work on your behalf in the months ahead. Let us know how we can help! 🌟■

RPA Capitol Hill Day WILL Occur on June 26 (But Virtually)

Even people who have been living in a cave for years understand the depth of societal change that has occurred in the last two months. Escalating mortality and illness from a novel virus, economic calamity, and a shutdown of all collective activities have transformed our society for now, and maybe forever. While there may be some positive outcomes from such fundamental restructuring down the road, the impact on some of the basic infrastructure of our country, most acutely health care delivery, has been devastatingly painful.

You know what hasn't changed? These things:

- ▶ That we live in a representative democracy where our elected officials debate issues of importance to our country and make policy decisions based on the will of their constituencies (hopefully), colored by their belief systems;
- ▶ That citizens have the right to assemble, and the right to petition their government for change, based on what they believe is right for the collective good of our country; and
- ▶ That every two, four or six years the citizens have the right to vote on whether their representatives should or should not continue to represent the congressional district, the nation, or their state, and thus keep or lose the right to make policy decisions.

For the purposes of this article we'll focus on the rights to assemble and petition the government, because we'll be discussing RPA's 2020 Capitol Hill Day. As this is being written, we are hopeful that we will be able to have the meeting in person, as usual in conjunction with the 2020 RPA Policy, Advocacy, and Leadership (PAL) Forum, but RPA leadership and executive staff are realistically considering that this decision may have to be revisited and the meeting will become virtual. **Either way, it is critically important for you to participate! Don't let the policy decisions referenced above happen without your input!**

If the meeting does occur in person, the process is a relatively easy, 'turn-key' operation. 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 (based on where they live and/or work). All of the arrangements for your visits will be taken care of for you. There is no fee to attend either Hill Day or PAL, and if staying for the full weekend, participants can have their travel expenses significantly offset. About a week or so prior to arriving in D.C., participants will receive RPA's legislative briefs on each of the issues described below, personalized schedules for the day, and other helpful



information. RPA staff will provide a detailed briefing the morning of the event to best prepare advocates for their day of meetings.

RPA is also prepared if the meeting goes virtual. Hill Day attendees will have access to an online platform, where you can login on your laptop/desktop to access your schedule. All you need is your email to login. In the Location field for each meeting, the conference line and access code will be displayed. Additionally, the platform allows for relevant information regarding the meeting: Time, Office of, Meeting With, Additional Attendees on the call, Team Lead, and Talking Points that allow for attachments/talking points material you may want to have in front of you during the call. Whether the meeting occurs in-person or virtually, attendees will be provided with tips on how to follow up with their legislator's offices and the best way to complete the feedback loop with the RPA office.

The issues on RPA's legislative agenda for 2020 are:

- Coverage for immunosuppressive drugs for the life of a kidney transplant (enactment of S. 3353 and H.R. 5534);
- Codification of improvements and further enhancement of living organ donation (S. 511 and H.R. 1224)
- Omnibus kidney disease legislation (enactment of S. 1676 and H.R. 3912); and
- Advocacy for transparency and accountability in the CMS quality measure development and review process for nephrology.

Given the shifting national tides, it is possible that topical issues such as refined use of telehealth in Medicare or economic relief for nephrology practices may be added to the Hill Day agenda; if that were to occur it will be in plenty of time for RPA staff to thoroughly inform Hill Day attendees.

Even in the midst of a public health emergency where we don't know what the next day will bring us, it is **CRITICALLY IMPORTANT** to engage with your elected officials to make sure nephrology's perspective is represented, either on longtime issues of consequence to the subspecialty or on issues arising in recent weeks. **PLEASE BE THERE** (either in-person or virtually).

For further information on RPA's Capitol Hill Day, please contact RPA Director of Public Policy Rob Blaser at 301-468-3515 or rblaser@renalmd.org. Please register today at <https://www.renalmd.org>. 🌟📌

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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OPKO Pharmaceuticals

RPA Welcomes Four New Board Members

RPA News recently interviewed RPA's newest Board members who began their terms of service in March. Even though we were unable to introduce them to the membership during the annual meeting, this article should provide readers with more insight about each of them.



During his first year of medical school, **Dr. Nishant Jalandhara** became interested in the physiology of the kidney. "I was drawn to taking care of really sick, complicated patients and making them feel better, which led me to a career in nephrology," explained Dr. Jalandhara.

"There are so many things in nephrology that are beyond our control, but for those things we can influence to improve nephrology practice and patient care, it is essential for us to be involved and voice our concerns, and share our recommendations with those in decision making positions. By serving on the RPA Board I have an opportunity to make a difference in the future of the specialty."

Dr. Jalandhara noted that there are many nephrologists who want to work from nine to five who aren't interested in getting involved or understanding the gears that grind behind the scenes to influence advocacy or policy development. As a leader on the Board, he intends to encourage more people to become engaged in RPA and increase interest in independent nephrology practice.

He stated, "We need to take advantage of the government's interest in kidney care at this point in time. The private sector is interested in innovative therapies and physicians have new opportunities to more efficiently and effectively improve patient care. But we still have work to do to remove regulatory and legislative barriers. Nephrology is heavily regulated and the current Administration is interested in helping to remove burdensome regulations."

Last year, Dr. Jalandhara ventured into solo private practice. "I'm glad I did it. While it was a difficult decision to arrive at, it was an important one. I could never thank my patients enough for their trust in what we do as a team. RPA has provided me ample guidance and made the transition easier."

Maintaining a healthy lifestyle may be key to Dr. Jalandhara's success. Father to two daughters and pursuing an active life including camping is challenging but fun. "Everyone is a hero, just make sure you rise when the call comes," he said.



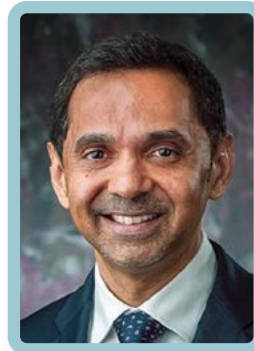
Dr. Katherine (Katie) Kwon caught her passion for nephrology during her residency at the University of Virginia where she had fantastic mentors. "I really liked the longitudinal relationship nephrology enables me to have with the patients. I see them through their diagnosis of chronic kidney disease to managing their care post-transplant," explained Dr. Kwon. "I am passionate about my patients. What else is there? I want them to have access to the best nephrology care, the latest innovations and optimal therapies. As a small-

town nephrologist, it is my responsibility to build a strong network of providers so I can bring the best care to my community."

As one nephrologist in a two-person practice in rural Michigan, Dr. Kwon has relied on RPA's assistance with billing and coding conundrums, compensation data, and practice resources. "RPA is a great organization to assist those of us in private practice and I am excited to serve on the Board and have the opportunity to work with people from across the country who have the same commitment to independent nephrology practice as I do," stated Dr. Kwon. "Early career nephrologists need the RPA, and I'd like to help them understand our value to their practices and their professional development. By increasing RPA's presence online via twitter and other forums, I hope I can spread information about RPA's expertise to grow the association."

According to Dr. Kwon, one of the most critical areas where RPA's advocacy can have an impact is on improving accountability and interoperability of electronic health record vendors. "The government has given these companies all the power. They collect our data and then charge us enormous sums of money for us to access the data we need to manage population health and make care decisions. This needs to change."

When Dr. Kwon is not caring for her patients, she enjoys spending time with her family, which includes two teenage boys. Her quarantine hobbies include cooking with reckless ingredient substitution, Peloton rides with Cody Rigsby (username @Nephrodite) and jigsaw puzzles.



Dr. Rajiv Poduval was fascinated by the seamless interplay of math and science in medicine which led him to pursuing a career in nephrology.

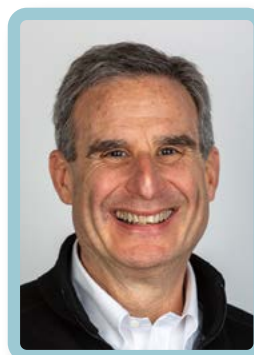
"Through my leadership roles at Southwest Kidney Institute, Global Nephrology Solutions, and the Renal Care Organization, I have had the privilege to interact with nephrologists from across the country. This has given me a unique perspective and understanding of both the opportunities and challenges innate to private

practice nephrology. Through the RPA Board, I hope to channel this experience to help keep nephrologists relevant, independent, and at the center of patient care delivery," explained Dr. Poduval. "I am humbled and honored by this privilege afforded to me and looking forward to being part of a forum where I can serve with, and learn from, thought leaders in the field of nephrology."

Dr. Poduval shared his perspective on the most critical issue facing the nephrology specialty and how RPA can best address it. "Over the past several years, there has been a systemic and systematic erosion of physician confidence, where we as a community have stopped believing we can take charge of our field. The RPA can restore that sense of confidence and purpose to the nephrology community as a whole through deploying its considerable resources to engage and empower nephrologists. There are three specific things RPA can do: be the glue that holds the nephrology community together; be our voice on Capitol Hill; and be the positive agent of change making volume-to-value relatable to nephrologists, so we can lead change together."

Dr. Poduval is a strong advocate for the 'Quadruple Aim', wherein CMS' Triple Aim is broadened to include a fourth aim focused on the 'Physician Experience.' "This is often referred to as the missing aim. We cannot succeed in delivering exceptional care if the physician community feels sidelined."

In addition to his commitment to kidney care and nephrology practice, Dr. Poduval enjoys running and a good round of golf. In another life, he might have been on the PGA Tour or been an elite runner, but for now he will take a mulligan.



After thinking about medical careers in pediatrics or emergency medicine, **Dr. David Roer** decided to pursue nephrology because he had great mentors who inspired him and taught him how to care for complex patients. After 30 years of teaching and providing clinical care to kidney patients, Dr. Roer wants to help drive the redesign of chronic kidney disease and ESRD care delivery at a national level. "By serving on the RPA Board, I have an opportunity to shape policies to help nephrologists remain independent and

successful in the changing world of value-based care," he explained.

"Nephrologists' engagement and leadership is critical to ensuring the future of the specialty. During a time when the workforce is shrinking, it is our responsibility to develop mentors like those I had during training who inspire interest in nephrology," Dr. Roer stated. "We need to reinvent training program curricula and develop upstream strategies for downstream solutions, such as teaching nephrology fellows how to deliver home dialysis therapies so they are comfortable providing that treatment option to patients when they are out in practice."

Dr. Roer is passionate about driving improved quality and ensuring patient safety. "RPA wrote a position paper years ago about the role of the nephrologist as the principal care provider. For kidney patients, the nephrologist should manage their care holistically versus nephrocentrically, and be the medical home for the patient. I hope I can help RPA advocate for the removal of payment and other barriers that prevent that from occurring."

Before Dr. Roer started medical school, he hiked the Appalachian Trail (2,000 miles) from south to north over 5 months carrying two weeks of supplies with him at a time. Fast forward to present day, he still enjoys hiking every weekend (scaled back a bit) and has also taken up cycling. ■

From Capitol Hill

from page 1

is the largest stimulus package in U. S. history. Of particular note to nephrology practices, the bill codifies a temporary waiver of the face-to-face visit requirement with home dialysis patients associated with CPT code 90966, and allows Medicare prescription drug plans to provide 90-day refills of covered Part D drugs, including immunosuppressive drugs for post-kidney transplant patients.

The bill also includes language that facilitates the provision of financial relief to physician practices affected by the pandemic. Significantly, the 2% reduction to Medicare fee-for-service claim payments (known as the Medicare sequester) is waived for the period beginning May 1, 2020, though December 31, 2020. This is a big deal, as the Medicare provider community, including physicians, hospitals, and dialysis companies, has been seeking a withdrawal of the sequester for years, with no success. CARES also establishes a financial aid program for Medicare providers to which physician practices can apply, announced by CMS, but to be administered by the Small Business Administration (SBA). Despite the urgency of the need for support to be provided to the small businesses that are physician practices, just prior to rollout, there was concern that the program was too much, too fast, and lacked the administrative guidance necessary to implement a program of this magnitude, and thus beyond the bandwidth of the SBA.

As for what comes next for Congress, at press time they are recessed until April 20, but that doesn't mean the jockeying for position in the next round of legislation hasn't begun. House Speaker Nancy Pelosi (D-CA), is already making plans for the 4th stimulus package, but Senate Majority Leader Mitch McConnell (R-KY) has been pumping the brakes on that talk, calling for the dust to settle on the most recent (and gargantuan) bill before proceeding to another. As per usual, the wild card in this scenario is the President, because while he owes much to Mr. McConnell (and despite the fact that he and Ms. Pelosi detest each other), his natural inclination is to do something, anything, so he might be in favor of another spending bill as well. Also, it might be the best thing for the country, so if Mr. McConnell continues to resist, he might be in a difficult position moving forward.

Of course, there were two months plus of legislating in D.C. that occurred before coronavirus changed everything (B.C.?), and that period included numerous developments affecting kidney policy. As has been the case for the last several years, while there was no lack of substantive policy issues being addressed on Capitol Hill, mega-events of early 2020 tended to take up a lot of the oxygen in Washington. The first days of January saw the Senate acquit the President of the charges levied in the House impeachment trial (this was of some interest to U.S. citizens), and the middle of the month included a campaign rally-esque State of the Union address like no other (including Ms. Pelosi's high profile tearing up of the written copy). Early February was marked by the release of the Administration's 2021 budget proposal (which, like all presidential budgets, is barely worth the paper it's printed on, digitally, but is an indicator of Administration priorities) and early March saw the onset of the coronavirus in the U.S., and the federal response, with attendant heated discussions of said response. And of course, all of this happened against the backdrop of a fairly unprecedented Democratic Presidential primary.

Of most interest to organized medicine broadly were efforts to enact surprise billing legislation, confounded by dueling bills from the committees of jurisdiction and a curious mix of odd bedfellows fronting the bills. The House Ways and Means Committee passed a bill supported by most of medicine that limits patient out of pocket costs and uses an independent dispute resolution (IDR) process to resolve differences between insurers, physicians and patients. The House Education and Labor (E&L) Committee seeks the same end goal, but includes a \$750 minimum threshold to trigger the dispute resolution process, which medicine vehemently opposes since most claims in question don't reach that threshold. Both of these proposals are in addition to a compromise package agreed upon in December by the Senate Health, Education, Labor and Pensions (HELP) Committee and House Energy and Commerce Committee, which is closer to the House E&L Committee's proposal, but not identical to it. The E&L bill support characterizes the curious blend of proponents/opponents as the committee leadership (Chair Bobby Scott, D-VA, a liberal Democrat, and Ranking Member Virginia Foxx, R-NC, and a far right Republican) led efforts to pass the bill, which was opposed by the two physicians on the committee, Reps. Phil Roe (R-TN, an OB/GYN and arch-conservative) and Kim Schrier (D-WA a pediatrician and liberal Democrat). While there is intense motivation to enact surprise billing

legislation in this Congress, the complexities of getting there seemed to make this a 50/50 proposition at best, even before COVID-19 changed everything.

Specific to kidney care, of course, the big news was the introduction of the Senate's version of the immunosuppressive drug coverage bill on February 27 (by name, S.3353, the Comprehensive Immunosuppressive Drug Coverage for Kidney Transplant Patients Act of 2020). Senators Bill Cassidy (R-LA) and Richard Durbin (D-IL) are the leaders on the bill, with Joni Ernst (R-IA), Jeanne Shaheen (D-NH), Sheldon Whitehouse (D-RI) and Todd Young (R-IN) joining as original co-sponsors. This bill is very close, but not identical, to the House bill introduced in December, with the differences concerning operationalizing integration of this coverage for individuals affiliated with the VA or the Indian Health Service. As for next steps, it was RPA staff's understanding that the managers of the House bill would draft language reconciling the differences between the bills to create a unified version, and then efforts would be made to gather sponsors, with a hope to ultimately get the bill included in the Medicare extenders package that was scheduled to expire on May 22. However, the CARES bill delayed the Medicare extenders expiration until after the election, so the likelihood of immunosuppressive drug coverage happening before then is small.

Elsewhere in the kidney legislation space, on February 13, the Lost Opportunities to Supply Transplantable Organs (LOST Organs) Act (S. 3317) was introduced by Senators Ben Cardin (D-MD) and Chris Van Hollen (D-MD) and Mr. Young. S. 3317 is bipartisan legislation to help prevent organs from being lost by requiring UNOS and other entities to better track organs and publicly report when logistical errors result in a lost, damaged or delayed organ. While the subject matter of this legislation is certainly worthy and meaningful, the guess here is that this bill's introduction is more symbolic than substantive, with the purpose being more to fire a warning shot across the bow of UNOS, the OPOs and the transplant centers regarding the issue of lost organs.

Another interesting development was that a discussion draft of a bill that would resurrect the ESRD PATIENTS Act, now known at the Bringing Enhanced Treatments and Therapies to ESRD Recipients (BETTER) Kidney Care Act, was released to the kidney policy community on February 7. The release of the discussion draft came as something of a surprise to many folks in the kidney policy community, particularly among the non-profit groups. Staff from the offices of Reps. Earl Blumenauer (D-OR) and Jason Smith (R-MO) and Senators Kyrsten Sinema (D-AZ) and Mr. Young were present at the roll-out meeting, and are expected to be the original co-sponsors of the bill, whenever introduction occurs. The legislation itself aligns pretty closely with what was included in previous versions, including what appears to be beefed up provisions around transplant metrics that are likely intended to address the transplant community's intense objections to the previous bill, although whether these changes allay their concerns is undetermined. The bill also continues to include a patient opt-out mechanism rather than an opt-in, which seems certain to cause some kidney patient groups to continue their opposition to the legislation. As for nephrology reimbursement, it appears to uphold what was included in the previous bill, reimbursing for professional services at current fee-for-service rates, and the closed network feature was removed, an improvement over the previous version of the bill.

The reemergence of the ESRD PATIENTS/BETTER Act is not necessarily occurring with a realistic goal of passing a bill in 2020. These low expectations for advancement are due to a combination of the following factors: (1) that as of early April, an actual bill has not yet been introduced; (2) the likelihood even before the coronavirus emergence that meaningful but not essential legislating will probably cease by the July 4 recess, if not earlier; (3) that some kidney groups feel that the Administration's payment model proposals should be allowed to move forward before Congress mandates further payment models in kidney care delivery; and (4) that the same divided opinion in the kidney policy community that scuttled the last bill will recur with this bill.

Readers, an editorial note: those last seven paragraphs or so were comforting to write, as they represented a return to discussing what would normally be discussed in this column. For those of you in a position to stay home, please do so as much as possible, and thank you for that. For those of you leaving home every day to treat patients and run practices, words fail at the task of expressing sufficient appreciation for what you do, but just the same, thank you as well. We will get through this. ■

The Value of the RPA in a Crisis

By Shaun Conlon, MD

This is part of a series of articles aimed at “young nephrologists” from Dr. Conlon’s perspective. This column does not represent the views of the RPA.



I am writing this article at the beginning of April. At this point, the coronavirus pandemic has been accelerating in the US for the past several weeks and around the world for longer. I could not have imagined earlier this year how much our personal and professional lives could change so much. I have discovered that it is not easy to homeschool or entertain my 3 and 5-year-old sons without access to playgrounds and the many children-friendly attractions in Atlanta. At work, I feel as if I have never been so busy while simultaneously seeing so few patients. My email inbox and meeting schedule is now entirely coronavirus centric.

Unfortunately, despite many months of planning, the RPA Annual Meeting had to be cancelled. I was looking forward to connecting with other nephrology professionals throughout the country at the meeting, and now I must struggle with the imposed physical disconnection created by the pandemic. However, I am reminded of the importance of maintaining my RPA membership, especially in a time of crisis.

RPA to the Rescue

I am reminded of a crisis in my practice that occurred several years ago. Due to an error on the part of our Medicare Administrative Contractor (MAC), our traditional Medicare payments suddenly ceased. Given that this was the source of 60% of our fee-for-service revenue, this caused a major disruption to our cash flow and business operations. As our practice worked to resolve the issue with our MAC, I reached out to the RPA for assistance. The RPA used its connections with the leadership at our MAC to help to expeditiously restore our Medicare payments. I was reminded of this problem when I was speaking with a colleague earlier this week at lunch – after merging with another group, their Medicare payments were also interrupted and had still had not been restored after multiple months. With the RPA’s help during my group’s crisis, our payments were restored within a matter of weeks.

RPA and the Current Crisis

Although the coronavirus pandemic is still early in its course (hopefully starting to improve by the time you read this), the RPA has already provided valuable information for nephrology practices. They have put together a dedicated page on their website with a repository of resources on how to navigate the pandemic. They are helping nephrology practices with the needed rapid transition to telemedicine. My practice has used their guidance with the billing, coding and regulatory aspects of this transition. There was a webinar in early April on this topic. The RPA has also provided information regarding financial assistance that is available for nephrology practices to help

weather the expected drop in revenue over the next several months (we will all almost certainly see our hospital and office revenue drop over the next several months).

As this crisis continues to unfold and eventually resolve, we should be fairly compensated for the ongoing care of our patients. The RPA serves as the nephrology representative on the AMA RUC (Relative Value Update Committee). This committee makes recommendations to Medicare regarding the appropriate payment level for our professional services. The RPA will continue to fight for fair payment for our services (for example, if the work for an office visit delivered via telehealth takes more time, then it should be reimbursed at a higher rate). The RPA also monitors regulatory guidance and makes comments about the regulations when needed. For example, they have helped to inform the membership regarding the rapid expansion of allowable settings for telehealth and the waiver of the requirement for a face-to-face visit for the complete hemodialysis visit (thus allowing the visit to occur via telehealth).

The RPA will also help to provide guidance on some of the larger nephrology programs and needed modifications to them due to this crisis. The QIP program for this year may need adjustment – it would be unfair to penalize dialysis units for higher rates of central venous catheters if their patients are unable to schedule surgery to create or revise arteriovenous fistulas or grafts. This is the last year of the ESCO program – it will be difficult to compare the cost of care this year to previous years thus complicating the calculations for shared savings or losses. In terms of the forthcoming value-based programs (KCF and CKCC), practices will need to recover from this crisis before being able to make the necessary preparations for successful participation in the programs. As changes to each of these is announced, the RPA will review the changes and make comments on behalf of nephrologists and our patients.

Some Parting Thoughts

The next several months will be difficult for all of us. By the time you read this, you will have had to navigate significant personal and professional stress. Hopefully many of you read my past columns regarding personal and practice finances, engagement and burnout and used some of those principles during these difficult times. I am thankful for the health of my family and friends and that I continue to work throughout this crisis and help people every day. The RPA will be your ally throughout these difficult times – please continue your membership to allow the organization to continue to support you and your practice. ■

Dr. Conlon has lived in Atlanta with his wife and family for over a decade. After finishing his residency and fellowship at Emory, he joined Atlanta Nephrology Associates where he is now a partner. Dr. Conlon serves as a member of the RPA Board of Directors.

Thank You for Supporting RPA’s Annual Meeting

On behalf of the RPA Board of Directors and staff, thank you to the many meeting registrants who donated their fees back to the association to offset the costs RPA incurred. Additionally, we appreciate the exhibitors who deferred their fees to secure their participation in the 2021 Annual Meeting in New Orleans. Lastly, we express our gratitude to the Education Committee for its efforts planning an outstanding 2020 Annual Meeting Program.

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Legal Issues: Some Lessons Learned (so far) in Risk Management From the COVID-19 Pandemic...

By James B. Riley, Jr.



As this article goes to publication, the nation is in the midst of the COVID-19 pandemic. Many lessons are being learned on how to and how not to respond to the pandemic, primarily from a clinical and public health perspective. However, from the standpoint of nephrology practices across the country, if and when things quiet down, there will be some time for reflection on how your practice functioned during these challenging times and what you did well, and what could be done better, should the circumstances arise again. While the

situation remains fluid, this article discusses some areas in the context of insurance coverage and contract negotiations that have become very important over the last several months.

Managing Coronavirus Risk Through Insurance

As governments, health officials and private companies work to mitigate and contain the threat of a potential COVID-19 pandemic, practices should be mindful of managing their risk through insurance. Even if you have not previously, there is no reason not to contact your insurance broker now to see what additional insurance might be helpful in the future. Several different types of coverage may be implicated, and to maximize protection, companies should assess their existing coverage and have a plan for giving notice to carriers and asserting claims if required.

Business Interruption Coverage and Contingent Interruption Coverage

As the world responds to the COVID-19 pandemic, many businesses have closed, either voluntarily or in response to governmental orders. Such closures are obviously going to have an adverse effect on revenues, and businesses should be assessing their available insurance coverage for lost income.

Some practices may have freestanding business interruption (BI), contingent business interruption (CBI) and civil authority coverage as part of their property policies. There is a good deal of uncertainty as to how that coverage may ultimately respond to COVID-19-related closures, and the answers will not be clear until the questions have been fully litigated. The trigger for BI and CBI coverage typically requires the insured to show “direct physical damage” to property. Whether COVID-19 virus contamination to insured or nearby property is sufficient to trigger coverage is an open question, with the answer to be decided under applicable law in each state. Some state lawmakers have proposed legislation to expand the scope of coverage for businesses in their states, but it is unknown what effect those may have. Even in the case of damaging hurricanes during the past few years, questions have arisen with coverage, and COVID-19 is even more of an issue.

Policyholders should take steps now to fully understand their coverage and protect their rights. First, remember that there are no clear answers on coverage. Opinions offered by brokers and risk managers, while well intentioned, should not be treated as the final word— particularly when millions of dollars may be at stake. Practices should ask an experienced coverage lawyer to analyze their policies and explain the available coverage. Any such analysis should include answers to the following:

- ▶ What is the trigger for BI or CBI? Usually it’s “direct physical loss or damage” or something similar.
- ▶ Does the policy contain an express exclusion for viruses?
- ▶ Does the policy have civil authority coverage for closure of the practice due to a government order? If so, what are the terms?
- ▶ When does the policy expire/renew?

Second, property policies cover losses that take place during the policy period. As current policies expire and are renewed, it is almost a certainty that carriers will insert COVID-19 exclusions in the new policies. The market has seen some examples of this already. Companies need to immediately understand when their policies expire,

so they can make an informed decision about whether to give notice of a claim under the current policy year while they still can. This is a delicate dance, as the property insurance market is hardening. For policies up for renewal, coordination with the company’s risk management department and insurance broker is vital to securing coverage going forward.

Third, policyholders should track any COVID-19-related losses they are experiencing. Insurers will require detailed proof of loss. Policyholders should consider setting up a separate accounting code to track losses.

Fourth, businesses that close voluntarily may have less of an argument for coverage than those who close because the government orders them to close. Companies should fully understand their coverage triggers to better inform business decision-making in this regard.

This is a time of great uncertainty, and there are no guarantees of coverage, but reasonable measures now can help preserve a policyholder’s rights as the issues become clear in the coming months.

Commercial General Liability Coverage

Commercial General Liability (CGL) policies may be implicated in a COVID-19 outbreak if customers or other business invitees become sick and allege they were infected on a practice’s business premises. Such a fact pattern would set up a negligence claim, and while the standard of care and proof of causation might present substantial obstacles to potential plaintiffs, companies would still face defense costs and the threat of adverse verdicts in plaintiff-friendly jurisdictions. Potential coverage issues include exclusions or endorsements for infectious disease, as well as additional insured status for contractors and building owners/managers.

Directors and Officers Liability Coverage

To the extent that a practice suffers substantial losses related to COVID-19, whether from loss of revenue or from tort claims, there is a follow-on risk against officers and directors alleging mismanagement, breach of fiduciary duty and malfeasance. Such claims implicate the company’s Directors and Officers (D&O) coverage.

What Practices Need to Do

Thus, practices should take immediate stock of their insurance programs with COVID-19 in mind. Carefully review existing policies to determine what coverage is available. Do not rely on verbal assurances or written summaries prepared by a broker or agent. Practices should also be aware of the notice provisions in each policy and be ready to put each carrier on notice as soon as claims arise.

It is also important to be mindful of when policies renew, as carriers can be expected to include COVID-19 exclusions with their renewals. If that turns out to be the case, then giving notice under the pre-renewal policies of “circumstances” and potential claims will be important to help secure available coverage. Of course, failure to give timely notice may forfeit coverage entirely. Finally, practices should seek experienced coverage counsel if an insurer denies or reserves rights on a claim, as many such denials and reservations are wrongful.

Contract Implications Amid COVID-19 Concerns: Force Majeure, Impossibility, and Frustration of Purpose

In the midst of the coronavirus pandemic, health authorities and federal, state, and local governments have issued proclamations, states of emergency, recommendations, and orders affecting the assembly and movement of people. With these actions, and likely more to follow, many companies have closed or curtailed business for the near future and cancelled or postponed events. Manufacturers and suppliers meanwhile struggle to meet demand for some products while the demand for other products has all but disappeared. While closure of their business has not to date applied to healthcare providers, there may be some impact, including vendors supplying your practice.

Today’s economy is built on written contracts, whereby parties reach a meeting of the minds and legally bind each other to perform certain acts in the future. Generally, the failure to perform under a contract

constitutes a breach, entitling the non-breaching party to damages. However, when the truly extraordinary and unexpected happens, three concepts may offer relief: force majeure, impossibility, and frustration of purpose. While the courts in different states do not interpret these legal principles the same, the intent here is to address the general concepts and their potential application because of the COVID-19 pandemic.

Force Majeure

Literally translated, force majeure means a “superior force,” and a force majeure clause is “a contractual provision allocating the risk of loss if performance becomes impossible or impracticable, especially as a result of an event or effect that the parties could not have anticipated or controlled.” A force majeure clause is one found in the contract, whether the product of negotiation or boilerplate, meaning language taken from an earlier agreement without much or any thought. An example of such a provision is as follows:

A party shall not be held liable for failure of or delay in performing its obligations under this Agreement if such failure or delay is the result of causes beyond its reasonable control, including but not limited to, an act of God, such as earthquake, hurricane, tornado, flooding, or other natural disaster, or in the case of war, action of foreign enemies, terrorist activities, labor dispute or strike, government sanction, blockage, embargo, or failure of electrical service.

A properly invoked force majeure provision relieves a party from performance under a contract when non-performance would otherwise constitute a breach. When a party’s invocation of a force majeure clause is challenged, with the other party claiming a breach of contract, the dispute may be resolved in litigation. Courts place the burden of establishing the conditions of force majeure on the party invoking the provision. While a court’s focus is the language of the force majeure clause, as it would be in any contractual dispute, a successful party must establish that: (1) the event that led to the non-performance was outside the party’s control; (2) the event was not specifically foreseeable; (3) the event was the sole cause of the failure to perform; and (4) the event could not have been avoided with the exercise of due care.

Impossibility/Impracticability or Frustration of Purpose

For contracts that do not have a force majeure clause, and in some instances even when they do, a party may raise the defense of impossibility or impracticability. Courts may read into a contract the concept that the parties intended to require performance only if commercially practicable. The Restatement (Second) of Contracts § 261 notes that a contractual obligation can be discharged when “a party’s performance is made impracticable without his fault by the occurrence of an event the non-occurrence of which was a basic assumption on which the contract was made.” Similar to force majeure, courts typically require the party to establish that: (1) a contingency has occurred; (2) the contingency made performance impracticable; and (3) the parties did not foresee the contingency when the contract was made. Due to the similarities between the defense and force majeure, some courts have merged the analysis and address them together.

Uniform Commercial Code § 2-615—which applies to, among other things, contracts related to the sales and leasing of goods—provides a similar defense “if performance as agreed has been made impracticable by the occurrence of a contingency . . . or by compliance in good faith with any applicable foreign or domestic governmental regulation.”

A similar but slightly different concept bears mentioning as well, frustration of purpose. The doctrine allows the discharge of a contractual duty when the “party’s principal purpose is substantially frustrated without his fault by the occurrence of an event the non-occurrence of which was a basic assumption on which the contract was made.” While courts recognize this concept, it has not been as widely developed as force majeure or impossibility/impracticability.

Application of Contractual Principles to COVID-19 Pandemic

A party’s obligation to perform under the terms of a contract will greatly depend on the language of the agreement and the underlying circumstances. The COVID-19 pandemic satisfies some, but not necessarily all, of the conditions necessary to relieve a party of performance.

For contracts entered before the pandemic reached the United States, the pandemic will likely be found to be a major external event, outside the control of the parties, and not foreseeable at the time of the

contract. Nevertheless, whether the pandemic made a particular party’s performance practically impossible could require a fact-based analysis that considers the terms of the contract.

Contracts entered during the COVID-19 pandemic are more likely to be enforced, as the party seeking relief could be deemed to have been aware of the challenges of performance.

Some have predicted that the pandemic will trigger a recession in the United States. Relying on Comment B to § 261, courts have held that “mere market shifts or financial inability do not usually effect discharge.” So non-performance due to the immediate effects of the pandemic may be excused, but non-performance as a result of a virus-induced recession may not. But some courts, consistent with the Restatement (First) of Contracts § 454, interpret impossibility/impracticability more broadly as “not only strict impossibility but impracticability because of extreme and unreasonable . . . expense[.]” Thus, post-pandemic litigation could focus on whether the economy makes performance “extreme and unreasonable.”

When force majeure and impossibility do not provide relief, a party may consider the defense of frustration of purpose. For example, assume a company has contracted to reserve a space for a celebration after an award ceremony scheduled for August 2020. The award ceremony itself is then canceled by an unrelated entity as a result of lingering concerns over the pandemic. While the event may be possible by August 2020, the organizer of the after-party may be able to invoke the defense of frustration of purpose because it was the principal purpose of the event to celebrate the awards ceremony.

Additional Considerations

A party considering whether to invoke force majeure or impossibility in order to excuse performance should consider whether a court would deem modified or delayed performance appropriate, rather than terminating the agreement. While some force majeure provisions provide clear guidance, many contracts present a quandary—to take the position that the contract is terminated due to the impossibility, or to attempt to perform to a lesser extent or at a later time. Restatement (First) of Contracts § 462 states that a temporary impossibility “suspends the duty of the promisor to render the performance promised only while the impossibility exists.” Restatement (First) of Contracts § 463 states that a partial impossibility affects the “existence of duty . . . only as to that part; and if performance of the whole contract is possible with only an unsubstantial variation, the promisor is under a duty to render performance with that variation.”

For example, a contract entered in November 2019 requiring a company to supply 1,000 cases of medical facemasks by April 1, 2020, may have been impossible to perform. The viability of the defense of impracticability or force majeure may be different, however, if the November 2019 contract required facemasks to be delivered over the next three years, or if, while the April 1 deadline could not be met, a May 1 delivery was feasible.

Notice Requirement

Whether under force majeure, impracticability, or frustration of purpose, a party not willing or able to perform under a contract must provide timely notice to the other party. The notice period and form of notice may be specified in the agreement, and otherwise should be “reasonable.” A party considering whether to invoke force majeure, impracticability, or frustration of purpose should carefully consider when and how to provide such notice, cognizant that the communication itself could be the key exhibit in a breach of contract action.

The application of a force majeure provision or the doctrines of impossibility or frustration of purpose in the context of COVID-19 will depend on the specific language of the contract, the applicable law, and the underlying circumstances leading to the non-performance. The potential for post-crisis litigation is significant.

Conclusion

Insurance coverage has always been an essential element of a prudent risk management strategy for any practice. In medical practices, the focus is usually and sometimes exclusively, on medical malpractice insurance, while other coverages are taken for granted without any analysis or receive little attention. The COVID-19 pandemic has shown that other types and levels of insurance can be at least equally important to assure the continuation of your practice.



RPA PAC Stays the Course in Uncharted Waters

suffice it to say, we live in a different world from when the last report on the activities of the RPA PAC appeared in the January issue of *RPA News*. This is especially true for the front-facing nephrologists and other health care professionals who comprise the RPA membership, and who continue to provide care to persons with kidney disease in challenging and difficult times without precedent. RPA staff appreciates you and salutes you without compunction or reservation; thank you, thank you, thank you.

Of course, this article could go on for 10,000 words of commendation and not be enough, and the purpose here is to discuss RPA PAC's efforts over the past few months to advance the cause of nephrology and kidney care on Capitol Hill, so that's what we'll do. Sadly, one of the activities that had to be cancelled in conjunction with the RPA Annual Meeting was the annual RPA PAC reception. Congresswoman Lisa Blunt Rochester (D-DE) was our invited guest. Representative Blunt Rochester is a member of the House Energy and Commerce Health Subcommittee and has cosponsored bills on two of RPA's 2020 legislative priorities, H.R. 5534, the Comprehensive Immunosuppressive Drug Coverage for Kidney Transplant Patients Act, and H.R.1224, the Living Donor Protection Act. Beyond that she is charming and engaging, so it's a shame we didn't get to spend time with her in Baltimore, but hopefully we'll be able to catch up with Congresswoman Blunt Rochester sometime soon.

In 2020, thus far RPA has supported events for Senators Todd Young (R-IN, longtime kidney care advocate with specific focus on transplantation issues), Mark Warner (D-VA), and Pat Toomey (R-PA). Senator Toomey is the Chair of the Senate Finance Health Subcommittee; Senators Warner and Young are also members of the SFC Health Subcommittee. On the House side, RPA PAC staff broke bread with Reps. Debbie Dingell (D-MI, and our angel on vascular access issues with CMS), Steven Horsford (D-NV, member of the Ways and Means Health Subcommittee and a rising star in the Democratic Party), Richard Neal (D-MA, and Chair of the Ways and Means Committee) and Cathy McMorris Rodgers (R-WA, and a

member of the House Energy and Commerce Committee). At every event, RPA staff has made the member of Congress aware of the immunosuppressive drug coverage bill, virtually always to a welcome reception. The fundraisers for Reps. Neal and McMorris Rodgers were particularly interesting. Mr. Neal, who in addition to being chair of the Ways and Means Committee is also a longtime Massachusetts pol who has forgotten more about legislative maneuvering than most of us will ever know, so listening to him discuss how things work (and don't work) on the Hill is always a treat. Ms. McMorris Rodgers was fresh off a trip to her home state, where she visited with Vice President Pence during his visit there to survey the early impact of COVID-19 in Washington.



One of the unfortunate effects of the cancellation of the RPA Annual Meeting relevant to the RPA PAC is that during the Annual Meeting the PAC receives the majority of its contributions for the year. The RPA PAC Board of Directors recognizes that in the current challenging times it may seem less than essential to donate to the RPA PAC. However, they would also note that in the massive disaster relief bill passed by Congress in late March was language making it law for CMS to waive the requirement for monthly face-to-face visits with home dialysis patients. Policy wins like this don't happen in a vacuum. RPA participates in community-wide efforts to raise the profile of kidney care issues on Capitol Hill, and the RPA PAC greatly facilitates the ability

of RPA leaders and staff to make the case on these issues with members of Congress and their staff. Please support RPA PAC in these critically important times. <https://www.renaldm.org/page/PAC>. ☆■

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.

Lessons Learned from COVID-19

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In addition, contract provisions, particularly the force majeure provisions, can become lifesavers in those unique circumstances such as we have experienced the last several months. While often negotiating these once in a lifetime provisions are chalked up to "overkill" or "never going to happen" provisions, these are the times when you wish you had them. Again, like insurance, they sometimes can mean the difference between the survival of a nephrology practice and its demise.

We will continue to learn from this unique event, but what is important is that each nephrology practice take stock of what they have learned and build upon it to further strengthen your practice. ■

Mr. Riley is a partner in the McGuireWoods Healthcare Practice and counsel to the Renal Physicians Association.

AUTHOR'S NOTE: *This article is for information purposes only and not for the purpose of providing legal advice. You should contact your attorney and/or tax advisor to obtain advice with respect to any particular issue or problem. The opinions expressed at or through this article are the opinions of the individual authors and may not reflect the opinions of the firm or any individual attorney.*



Telehealth Changes During Public Health Emergency

Readers of this column are aware that there have been profound changes in the coding and billing for services provided to Medicare beneficiaries during the COVID-19 public health emergency, mostly pertaining to the use of telehealth and remote care. This month's column focuses on those changes.

Q Which place of service and modifier should I use for submitting claims for telehealth services? I know these have changed in recent weeks.

A The need for physical distancing during the public health emergency (PHE) has tremendously accelerated the integration of telehealth in health care delivery, and this has necessitated CMS making changes to how these claims are submitted. Prior to March 30, the process for submitting a claim was to use place of service (POS) -02, without a modifier. This process had been in place since January 1, 2018, when CMS sent out instructions that, "Effective January 1, 2018, the use of modifier GT on professional claims has been eliminated. Use of the telehealth POS code 02 certifies that the service meets the telehealth requirements." [The GT modifier had been previously required.] Even with the initial expansion of telehealth use with the elimination of originating site and geographic restrictions that occurred on March 17, CMS direction to use POS -02 without a modifier for telehealth claims was unchanged.

However, the Agency revised this process with the March 30 interim final rule (IFR) that made numerous revisions to then-existing telehealth policy. First, CMS instructed physicians and practitioners who bill for Medicare telehealth services to report the POS code that would have been reported had the service been furnished in person. This is a change from the recent previous policy where POS -02 for telehealth was to be used. Their rationale is:

This will allow our systems to make appropriate payment for services furnished via Medicare telehealth which, if not for the PHE for the COVID-19 pandemic, would have been furnished in person, at the same rate they would have been paid if the services were furnished in person. Given the potential importance of using telehealth services as means of minimizing exposure risks for patients, practitioners, and the community at large, we believe this interim change will maintain overall relativity under the PFS for similar services and eliminate potential financial deterrents to the clinically appropriate use of telehealth.

Additionally, CMS instructed Medicare providers to use a new modifier with telehealth codes during the PHE, -95. This is another change from recent previous policy, where modifiers were not required for standard telehealth claims. It is worth underscoring that these changes do not affect reimbursement.

Q Can all of the MCP visits, including the complete assessment of the patient, be provided by telehealth?

A Yes, the March 30 IFR clarified that all of these visits can occur via telehealth. Previously, there had been some gray area here, for a couple of reasons. First, the single-visit in-center MCP codes (CPT codes 90956, 90959, and 90962) did not appear on the approved telehealth list, since originally only MCP visits 2-4 could be provided by telehealth. This meant that when the originating site and geographic restrictions on all of the approved telehealth services were lifted, the assessments associated with single visit codes technically still had to be provided face-to-face, even though that seemed contrary to CMS' overall emphasis on physical distancing. Secondly, there were differing interpretations after March 17 as to whether the complete assessments associated with the MCP still needed to be provided face-to-face; the IFR adds all outpatient dialysis services to the list of services that now can be fully provided via telehealth means. Additionally, in the text of this portion of the rule, CMS notes that:

Therefore, in the context of the PHE for the COVID-19 pandemic, we believe all of the following services (this list

included all of the outpatient dialysis codes) meet the category 2 criteria to be added to the list of telehealth services on the basis that there is a patient population that would otherwise not have access to clinically appropriate treatment. We note that, as with other services on the Medicare telehealth list, it may not be clinically appropriate or possible to use telecommunications technology to furnish these particular services to every person or in every circumstance. However, in the context of the PHE for the COVID-19 pandemic with specific regard to the exposure risks noted above, we recognize the clinical benefit of access to medically reasonable and necessary services furnished using telecommunications technology as opposed to the potential lack of access that could occur to mitigate the risk of disease exposure.

The rule also includes a section entitled "Required Hands-on" Visits for ESRD Monthly Capitation Payments" where they cite the 2005 fee schedule rule in which CMS specified that the required clinical examination of the vascular access site must be furnished face-to-face "hands on" (without the use of an interactive telecommunications system) by physician, clinical nurse specialist (CNS), nurse practitioner (NP), or physician assistant (PA). For the duration of the PHE, this requirement has been lifted as well, and as with the additions to the telehealth list, this revision applies to all outpatient dialysis services, CPT codes 90951-90970.

Q Do the recent policy changes allow doctors to use telehealth to see new patients? I know that this was not allowed before.

A Yes, CMS has stated publicly that telehealth services can now be provided to new patients. In their March 17 Frequently Asked Questions document released after the first round of telehealth policy changes, one of the FAQs was "Will CMS enforce an established relationship requirement?", and the Agency provided the following response:

No. It is imperative during this public health emergency that patients avoid travel, when possible, to physicians' offices, clinics, hospitals, or other health care facilities where they could risk their own or others' exposure to further illness. Accordingly, the Department of Health and Human Services (HHS) is announcing a policy of enforcement discretion for Medicare telehealth services furnished pursuant to the waiver under section 1135(b)(8) of the Act. To the extent the waiver (section 1135(g)(3)) requires that the patient have a prior established relationship with a particular practitioner, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.

Q I've heard that Medicare is allowing the use of telehealth much more widely with the COVID crisis. Does this provide coverage for phone calls?

A CMS has expanded coverage for physicians and other health professionals such as nurse practitioners and physicians assistants to interact with the patients on audio-only phone calls (details below), but first it is important to make a distinction between tele-health and the Medicare coverage of tele-phone services. When CMS makes reference to telehealth, in the vast majority of circumstances they are specifically referring to real-time, interactive, audio-video encounters where both parties can see and hear each other. This means that the codes on the approved telehealth list are only covered if provided via real-time, interactive, audio-video technology; a simple audio-only phone call does not suffice.

However, for the duration of the PHE, CMS did change the status indicators for the family of audio-only telephone service codes from an inactive status ('N' for non-covered) to an active status ('A', indicating a covered service). This applies to CPT codes 98966-98968 for qualified non-physician health care professionals (such as nurse practitioners—NPs, and physician assistants—PAs) and for CPT codes 99441-99443 (for physicians). So, Medicare providers can now be paid for audio-only

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The COVID Experience

By Anika Porter, M.Ed



In early March, we were all preparing to participate in the RPA 2020 annual meeting. My goal as a speaker and committee member was to bring our members information on how we were capitalizing on ancillary programs within the practice. As COVID-19 began to take over our nation, our worlds began to take on new meaning. Every conference, spring break or local activity was canceled. Medical professionals were trying to figure out their place. I can't begin to tell you how many practices I encountered

that feared losing employees and having to cease operations. Personally, our practice didn't have those conversations, and I was completely grateful. Our conversations with our staff focused on supporting them and letting them know we understood their fears. We told them how to properly protect themselves, our patients and their families. We also discussed with our staff how we were going to alter the day to day operations of the business. Importantly, we were, in fact, still in business.

Our practice had telemedicine, chronic care, remote patient management, and other activities active in place, and we knew that we had to work even harder to remain consistent in sustaining our practice. To keep our practice moving, we fine-tuned the following:

- **Chronic Care Management and Remote Patient Monitoring:** We made sure that the patients who weren't consistently reporting were called weekly to get a report. If they were not using the app to report, we determined why and moved expeditiously to get them using the program. We split our list among our clinical staff and made weekly calls to obtain data from our patients.
- **Telemedicine:** We slowly rolled out and identified which insurance companies would provide coverage for telemedicine services, since we are attached to several Medicare Advantage plans and HMOs in our area. We found ourselves increasing enrollment rapidly and communicating with patients instantaneously regarding their care. We offered telemedicine to the patients and, contrary to popular belief, the elderly patients adapted and accepted the change quickly. On the home page of our website we added a link for a HIPPA compliant form that could be filled out on any electronic device, signed with a finger or by typing, and sent electronically through the portal. We know that many of the restrictions have been lifted, but we all know consistency is key. If patients didn't fill out the consent form online we could email or text the form, or obtain verbal consent when staff called before the visit. The staff called to ask the already scheduled patients if they would commit to telemedicine. Those who agreed were contacted within 24 hours of the appointment to reconcile medication, and they received instructions on accessing the site. The final instruction given was that the patient should take their blood pressure 30 minutes before the call and have the machine available for the physician. Of course, there are obstacles, but not many that aren't quickly resolved.

- **In office visits:** These are still inevitable, but we have no more than six patients in a full day. We call the patients and inform them of our protocol. We do not waver in our commitment to these processes. Patients are screened with the COVID-19 questions released by the CDC. Only one person is allowed to accompany the patient. All patients are screened again outside of the suite near the entrance door, given a mask and hand sanitizer.
- **Protection of the staff:** Our initial protection started with social distancing in the waiting area. We removed over half of the chairs in our waiting room and put the remaining chairs at least six feet apart. We were asking the COVID questions at the reception desk, but soon moved a staff member to the entrance of the suite fully protected in PPE. One of the physicians had a brief meeting to demonstrate properly wearing a mask, placing masks on the patients, using other PPE and proper handwashing. The conversation ensured that the staff were to ultimately protect themselves, and showed our commitment to their safety as well as the patient's. Our patients are paramount, but our staff is our family. We sanitize areas as soon as patients leave the area. I smile when I see someone taking initiative, like using disinfecting wipes to wipe down the doorknobs, because this confirms that we are diligently working at limiting the spread.
- **HR:** It has been difficult to maintain momentum, but we continue to thrive. Our staff has been trained to remotely work. This is not a normal business practice, but it is inevitable. There are signed remote employee agreements. We've set up phones for some to have at home in the event of them being quarantined or having to close the office. We have mini staff meetings just to discuss their concerns and address their feelings. We practice social distancing in the office and at lunch. We have an employee quarantined because of a family member's possible exposure, and her contribution to the team has not gone unnoticed while she isn't in the office.

I'm certain that I don't possess all of the answers, but I rest assured that daily I am helping our practice as well as my clients' practice survive in the midst of uncertain times. It has been stressful. to say the least, to learn that not everyone believes in the seriousness of COVID-19. Patients are still not being completely transparent, and by the end of the conversation, one may determine that they may be symptomatic. In our world, we consider everyone we encounter may be positive, so we must always be cautious. Although we've had some bumps in the road, we are still standing and fully staffed. Thankfully, some of our previously implemented programs and services provide us with financial stability, as well as enable us to provide our patients with the best care that we can give.

I encourage all of you to continue to think of additional services to grow your practice that will sustain your future. This pandemic has taught us all that we have to be open to change, because change is inevitable. ■

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telephone calls. The RVUs for the two code families are identical, as are the time parameters, all of which are listed below, with the unadjusted national payment amounts based on the 2020 Medicare conversion factor of \$36.09:

CPT codes 98966/99441	(5-10 minutes)	0.40	\$14.43
CPT codes 98967/99442	(11-20 minutes)	0.78	\$28.15
CPT codes 98968/99443	(21-30 minutes)	1.14	\$41.14

RPA's guidance on telehealth is posted in the COVID HUB at www.renalmd.org and will be updated as warranted. ★■

Editors 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. Similar to the FAQ page on the RPA website, 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 PAL Annual Forum: Policy, Advocacy and Leadership in an Uncertain Time

Due to the coronavirus pandemic, the RPA staff and leadership have decided to convert the in-person RPA PAL Annual Forum into a virtual event that will occur all day Saturday, June 27. Please visit www.renalmd.org for the latest program information.

RPA's Policy Advocacy Leadership (RPA PAL, formerly NCAP) program prepares nephrology practitioners and practice administrators to become leaders in advocating for nephrology coverage and payment policies that preserve full access to quality kidney patient care.

Each year, the RPA PAL subcommittee plans a unique program to address relevant topics affecting nephrology practice, and the 2020 Advocacy Forum – scheduled for June 27-28 – will take a deep dive into several timely issues. First and foremost, the Forum will be extended to a full day on Saturday, June 27, to accommodate several of the sessions that were originally planned for the RPA Annual Meeting in March. These sessions will highlight the kidney models associated with the Advancing American Kidney Health Initiative as well as maximizing the pipeline for kidney transplants. Additional key topics will include better care for CKD patients, telehealth, highlights of local and regional issues being faced by nephrology, and communication and leadership.

In addition to educational sessions, the Forum provides ample opportunities for informal discussions and networking. Regarding the Forum, one nephrologist noted, “You will learn things that you would not learn anywhere else. You will have face to face time with leaders in the nephrology community in a small setting.” The Forum allocates time for roundtable discussions as well as casual conversations.

These networking opportunities are intergenerational as well. The Forum brings together nephrology practitioners with many years of experience and those who are new to practice to share and exchange ideas. In the words of a past attendee, “To fellows, those in training and those coming out, there’s probably not a better introduction to policy than the program. It’s large enough to give you networking opportunities yet an intimate enough environment that you can’t get

in any other place. For the older people trying to understand wild changes, there’s not a more efficient use of your time to get up to speed on those things than the PAL program.”

Now in its 18th year, the Forum highlights work being done in the field by nephrologists and provides insights on how it may translate to your own community. For example, feedback from an attendee at the 2019 Forum session featuring Rebecca Schmidt, DO, on the Role of Nephrologists in Public Policy stated, “It demonstrated real, significant results from years of being active in developing relationships – it showed us that it is possible.” Another 2019 session, Case Study: Access to Care and Outcomes Among Undocumented Immigrants with Kidney Failure featuring Lilia Cervantes, MD, Aubrey Hill, MPP, and Andrew Brookens, MD, was described by an attendee as a “tangible blueprint to assist with advocating at a local level – this is what PAL is all about.” Other 2019 topics included policy leaders such as Kathleen Blackwell, MPH, Model Lead for the Comprehensive ESRD Care (CEC) Model at CMMI, speaking about Innovation in Chronic Disease Management: Insights for Nephrology. Sessions also focused on the State of Integrated Care Models for Kidney Care, a Washington Update, State Efforts to Protect Living Donors, and more.

Forum attendees interested in local policy development gain insight into coverage, regulations, and reimbursement issues that not only affect the bottom line, but also impact the way patient care is delivered. As noted by one past attendee, “[RPA has] an understanding of policy and the business of the nephrology profession and the ability to advocate with policymakers across the spectrum of the field.”

Take advantage of this great opportunity to learn about the issues affecting nephrology practice and engaging with your peers by participating in the RPA PAL Forum. There is no cost to participate but registration is required. Register at www.renalmd.org. Any questions about the PAL Forum or the PAL program should be directed to abeckrich@renalmd.org. ☆■

RPA PAL is supported by a grant from Amgen.



Public Policy News Briefs

- ▶ **RPA Commends HRSA on LOD Proposed Rule** – On February 18, RPA submitted comments to the Health Resources and Services Administration (HRSA) on its proposed rule on Removing Financial Disincentives to Living Organ Donation. RPA's comment which can be reviewed at https://cdn.ymaws.com/www.renalmd.org/resource/resmgr/legregscmp/federal_agencies/lo_d_hrsa_nprm_com_2-2020__00.pdf commends the agency for developing processes to promote living organ donation via the removable of unnecessary barriers to donation, and also calls on HRSA to facilitate the ability of non-directed donors to successfully apply for support by removing the requirement that a non-directed donor wait until a recipient is identified before applying for reimbursement.
- ▶ **RPA Comments on OPO CFC Address OPO Recertification, Accounting for Risk Tolerance** – On February 21, RPA submitted comments to CMS on its proposed rule to revise the conditions for coverage for organ procurement organizations (OPOs). RPA's comments, which can be found at https://cdn.ymaws.com/www.renalmd.org/resource/resmgr/legregscmp/federal_agencies/opo_nprm_2-2020_com_final.pdf, addressed the use of comparative metrics for defining OPO success, assessment of transplantation rates by organ type, changes in the OPO recertification process, and accounting for heterogeneity in risk tolerance among transplant centers.
- ▶ **CMS Releases Final Rules on Interoperability, Patient Access to Health Records** – On March 9, CMS released two final rules (<https://www.healthit.gov/curesrule/> and <https://www.cms.gov/newsroom/fact-sheets/interoperability-and-patient-access-fact-sheet>) intended to facilitate patient access to their health records and to promote interoperability with the health care system. These rules, issued by the HHS Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS), implement interoperability and patient access provisions of the bipartisan 21st Century Cures Act (Cures Act). RPA submitted comments on the ONC rule and the CMS rule in June of 2019. The comments may be found at the following links: https://cdn.ymaws.com/www.renalmd.org/resource/resmgr/legregscmp/federal_agencies/rpa_onc_2019_comment_letter_.pdf and https://cdn.ymaws.com/www.renalmd.org/resource/resmgr/legregscmp/federal_agencies/rpa_cms_2019_comment_letter-.pdf.
- ▶ **Kidney Community Letter Calls for Robust Kidney Research Budget** – On March 13, a broad group of kidney care and kidney adjacent groups came together to send a letter to the Appropriations Labor-HHS-Education Subcommittees in both the House and Senate calling for robust funding increases for the NIH and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). The groups requested that as the committees draft funding legislation for FY 2021, NIH be increased by \$3 billion over FY 2020, with at least a proportional increase for NIDDK. Additionally, the groups urged the committees to consider a Special Statutory Funding Program for Kidney Research at \$150 million per year over 10 years. The letter can be found at https://cdn.ymaws.com/www.renalmd.org/resource/resmgr/legregscmp/congressional/3.12.20_niddk_fy21_appropri.pdf. ☆■

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RPA
Renal Physicians Association

**Learn more at www.renalmd.org/getinvolved
All nephrology professionals and practice administrators are invited to participate.
REGISTRATION NOW OPEN!**

We have turned our in-person program to an engaging virtual learning experience. Watch your email and the RPA website for more information on how to attend Capitol Hill Day and the RPA PAL Forum via your desktop or mobile device.

