

RPA News SPECIAL EDITION

Year in Review

By Jeffrey A. Perlmutter, MD

As we all know, this has been a year like no other. The second year of my term as your President began with the national shutdown due to the coronavirus pandemic. Up until one week prior to the kick-off of RPA's 2020 Annual Meeting, we thought we would be seeing you in person in Baltimore. Unfortunately, that did not occur, and one year later we are holding our first fully virtual annual meeting March 18-20. I hope to "see" many of you on the computer screen this month.

During the first year of my presidency, the RPA Board, along with several invited guests representing diverse stakeholder groups, met in October 2019 to create a strategic plan to focus the association's activities for the next two to three years. Of course, we had no idea at that time that a few months later, the world would be turned upside down. Our Board revisited the strategic plan at our January 2021 meeting to assess where progress had been made and where changes were needed. In spite of the pandemic, many of the tactics identified in 2019 were implemented in 2020 and highlighted in this article or will be implemented in 2021.



Jeffrey Perlmutter, MD
RPA President

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RPA Celebrates 2020 Advocacy Victories

RPA's strong advocacy on Capitol Hill and with federal agency officials resulted in significant legislative and regulatory achievements benefitting nephrology professionals and kidney patients. Highlights of those successes are provided below.

- ▶ In late December, Congress passed the Consolidated Appropriations Act, including a provision **extending immunosuppressive drug coverage for the life of the transplant**; this has been one of RPA's legislative priorities for over ten years. Additionally, the bill reduced the scheduled -10% cut in 2021 Medicare reimbursement to less than -3.5% and made it easier for physicians in Advanced Alternative Payment Models (AAPMs) to qualify for the 5% bonus in these programs.
- ▶ **CMS revalued all codes in outpatient dialysis code family—worth ~\$270 million to nephrology as a specialty**
 - CPT codes 90951-90970, representing the monthly capitated payment (MCP) family of services, all have RVU (value) increases between 13-27%.
- ▶ **11% increase for nephrology payment effective January 1, 2021**
 - The 11% increase is due to the MCP coding increases and the year-end funding bill that maintained dialysis and E&M code revaluations and minimized the proposed cut in the Medicare conversion factor.
- ▶ **CMS revised policy to pay ESRD MCP funds under the Comprehensive Kidney Care Contracting (CKCC) model directly to the nephrologist, at billed level (i.e., the 4-visit level)**
 - Original proposals would have provided these funds to the CKCC entity, delaying nephrology practice payment, and would have paid 4-visit codes at the 3-visit code level.

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From Capitol Hill

Triumph and Tumult on Capitol Hill

By Robert Blaser, RPA Director
of Public Policy

Capitol Hill has been the locus of more than its normally huge share of news in recent weeks, and for editorial purposes, we will dispose of the elephant in the room before discussing the more typical content of this column. The events of January 6 were horrific, disheartening, and abhorrent. As a lifelong resident of the D.C. Metro area who was born about 22 blocks from the Capitol in a hospital that no longer exists, I can vouch for the fact that the pain that I and other D.C. area residents felt that day was deep and visceral. That said, the democratic norms of our republic, though battered, held up that day and in the weeks after. A supposedly true and often told story is that when Ben Franklin was asked after the Constitutional Convention in 1787 "Doctor, what have we got? A republic or a monarchy?" he replied, "A republic, if you can keep it." For the moment, we're keeping it.

Prior to the chaos, THE IMMUNO BILL PASSED!, plus there was great news regarding physician reimbursement. Leading up to this great news, in the last quarter of 2020, the activity in Congress was its usual amalgam of indolence, bluster, bravado, hurrying up and waiting, and last-minute deal cutting. All along, the expectation was that funding the federal government with a hoped-for COVID relief package would occur in the post-election lame-duck session of Congress, and while it took longer than it should have, and included some predictable twists courtesy of the White House, happen it did. Other questions around the package if it were to occur centered on how long the government would be funded (short term or until the September 30th end of the 2021 fiscal year), would COVID relief happen, and if so, how big would it be, and what other issues would be resolved along the way.

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The Year in Review

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Our vision to champion excellence in kidney care and forge the future for the nephrology profession serves as the underpinning for all we do. Our tactics support the association's mission as stated below.

RPA empowers nephrology professionals through:

- Leadership development and mentorship
- Regulatory and legislative advocacy
- Development and promotion of best business and care delivery practices

Over the last 12 months, while all in-person events were put on hold, RPA pivoted to expanding its digital footprint and virtual offerings. Last April, RPA launched a **COVID HUB** at www.renalmd.org where we post billing and coding guidance, telehealth regulations and requirements, communications with Congress and federal agencies, the Centers for Medicare and Medicaid Services (CMS) resources and other federal guidance, patient education, and peer-reviewed literature. New documents are frequently added to the HUB.

Beginning last April, RPA offered numerous **webinars** on COVID-related topics as well as clinical issues affecting nephrology practice. We also presented our popular coding and billing seminar as a four-part series virtually in the spring. All of these webinars are available on demand on RPA's elearning portal on the website.

Hill Day and the 2020 PAL Forum were delivered virtually in June, and participation reached an all-time high. Since nephrology professionals didn't need to take time to travel to Washington, D.C., we expanded our reach and included participants from as far away as Hawaii and Alaska. In late 2020 RPA embarked on a project to better understand **Medicaid policies** affecting kidney care. After reviewing a landscape analysis on Medicaid policy trends and survey data from stakeholders, RPA will develop a policy agenda and action plan to influence Medicaid policies in key states.

RPA was successful on the national stage in the **advocacy** arena over the past year. Our regulatory lobbying efforts reaped rewards in the 2021 Medicare Physician Fee Schedule, with nephrology slated for an 11% increase in reimbursement this year. Additionally, the extension of immunosuppressive drug coverage for the life of a kidney transplant was passed by Congress and signed into law by the President at the end of 2020—this has been an RPA legislative priority for about 10 years. Persistence pays off! Highlights of RPA's advocacy success are provided on page 1.

Included among the cancellations of our in-person events last year was our PAC reception, which has traditionally been held in conjunction with our annual meeting. We honored Congresswoman Lisa Blunt Rochester (D-DE) at a **virtual PAC Reception** in late September. Ms. Blunt Rochester was a member of the House Energy and Commerce Health Subcommittee, with jurisdiction over the Medicare program, and has served as the U.S. Representative for Delaware's at-large congressional district since 2017. She also served on the Biden campaign steering committee and as a member of the Vice-Presidential search committee. Additionally, she cosponsored H.R. 1224, the Living Donor Protection Act of 2019, and H.R. 5534, the Comprehensive Immunosuppressive Drug Coverage for Kidney Transplant Patients Act of 2019. During the virtual event, PAC contributors engaged in an interactive conversation with the Congresswoman, who was very interested in and concerned about how nephrologists were holding up and what challenges we were facing in providing kidney care during the pandemic.

It became apparent in late fall of 2020 that it would not be safe to host an in-person annual meeting in March 2021. Therefore, the education committee under the leadership of Drs. Gary Singer and Brendan Bowman proceeded with planning a relevant and interactive **virtual annual meeting** scheduled for the same dates—March 18-20. I hope you will join us for outstanding, unique content and an opportunity to participate in panel discussions and ask questions. More details about the annual meeting are provided on page 10. Thank you to the education committee and staff for taking on this Herculean challenge and rising to the occasion.

RPA took our Prezmobile virtual as well. We met with Dallas Nephrology in December and Delaware Kidney in February to provide

updates on legislation and regulations affecting nephrology practice and kidney patients. Contact the RPA office if you'd like us to join your **virtual practice meetings** and offer a brief update on current issues that impact your small businesses and patient care.

At the end of 2020, RPA launched its **mobile app** so you can keep up with the latest legislative, regulatory, and association news on all of your devices. The app is free and can be downloaded from the Apple or Google Play stores. In addition to receiving real-time updates on issues affecting your practice and your patients, you can connect with your colleagues, pay your dues, post questions on various discussion forums, register for meetings, and much more.

In January, RPA awarded five **public policy fellowships** to early-career nephrologists (in practice five years or less) to increase their understanding of the importance and impact of advocacy. (Meet the first fellows cohort in the article on page 14.) During the 12-month fellowship through participation in RPA Board of Directors meetings, committee meetings, and national events, including Capitol Hill Day and the PAL Forum, these fellows will learn how to shape kidney health policy and position the specialty for success in the coming years. In July, RPA will award five public policy fellowships to renal fellows with the same goals in mind.

Over the years, RPA has written many guidance documents and position papers on critical issues affecting our profession. All of these references are available free to members in the store on the RPA website. Last year RPA released two new publications. First, the *RPA Position Paper on Peritoneal Dialysis Urgent Starts* focuses on the considerations for an urgent start program and best practices for urgent start peritoneal dialysis (PD) for patients with end-stage renal disease (ESRD). Second, the *RPA Position Paper on Dialysis Facility Medical Director Responsibilities Under the Revised CMS Conditions for Coverage for End-Stage Renal Disease Facilities* was updated and expanded from the last iteration completed in 2009 to reflect the changing responsibilities of the medical director. Most recently, the RPA Board approved *Guidance for Optimal Advanced CKD Care* to assist nephrologists with implementing processes for providing care to and billing for high-risk Stage 3, 4 and 5 Chronic Kidney Disease (CKD) patients. I encourage you to download these documents from the RPA store.

As previously reported, RPA's Kidney Quality Improvement Registry provides us with a platform to report Quality Assurance and Performance Improvement (QAPI) participation and obtain MOC credit, as well as an opportunity to conduct research on real-world nephrology practices. In 2019 RPA completed the first project which focused on the impact of hyperkalemia on CKD patients. In 2020 RPA embarked on our second research project: *Assessment of Nephrologist Practices in Managing Mineral Bone Disease in Patients with Advanced Chronic Kidney Disease*. Working with 10 nephrology practices, this study is exploring nephrologists' perceptions (through clinician interviews) and actions (through chart reviews) around guidelines for managing calcium, phosphorus, parathyroid hormone (PTH), and Vitamin D (e.g., Mineral Bone Disease (MBD)) in CKD patients. We expect to share the study results later this year.

RPA is fortunate to have dedicated volunteers who contribute freely of their time and talent, enabling us to conduct our important work on behalf of the profession. My sincere thanks to outgoing Board members Drs. Robert Fuld and Robert Kenney. It has been a privilege working with each of them over the past six years. Additionally, Dr. Rebecca Schmidt will complete her service on the Board after 14 years. She served as my counselor on the executive committee and shared her wisdom and valuable input as a former RPA president. Becky will be missed at the RPA Board table but will continue to be involved as one of RPA's delegates to the American Medical Association. Each of these individuals will be recognized for their service to the RPA during the annual meeting.

The RPA Board is well-positioned to tackle the challenges on the horizon as we welcome three new members this month: Dr. Brendan Bowman (Charlottesville, VA), Dr. Alexander Liang (Dallas, TX), and Dr. Samaya Anumadu (Houston, TX). More information about these nephrologists and their areas of expertise will be shared in the May issue of *RPA News*.

The Year in Review

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As I hand over the gavel to Dr. Tim Pflederer, I wish him and the other officers (Dr. Keith Bellovich, President-Elect, and Dr. Gary Singer, Secretary-Treasurer) much success in the coming year. Serving as your President has been an honor and a privilege. I encourage you to become engaged in your professional society and join one of our committees to assist us with charting our future.

Importantly, in January, the RPA office downsized to a smaller space to save rental costs and acknowledge the movement to increased telework. The new suite (#320) in the same building on Rockville Pike in Rockville, MD, is sleek and was designed for working in the post-coronavirus world. Since my practice is only minutes away from the RPA office, I was fortunate to see the new space. When it is safe to

travel, I encourage you to stop in to visit the staff who haven't missed a beat during the pandemic and continue to deliver quality programs and services to nephrology professionals.

If you watched the video message I recorded with Dale Singer earlier this year, you heard my plea for your continued support of RPA in 2021 and beyond. Advocacy is a marathon, not a sprint, and you can read about the fruits of our labors on your behalf described throughout this newsletter and on our website. Successes like these result from your commitment to your specialty through time and money. When it is time to renew your membership or contribute to the PAC, please do so without hesitation in recognition that RPA is always fighting on behalf of nephrology practices. Thank you! ♦

RPA Celebrates 2020 Advocacy Victories

from page 1

- ▶ **CMS adopted RPA recommendations in ETC final rule**
 - Originally the ETC scope included 50% of the U.S., which was reduced to 30%, the bonus-penalty span was reduced from +11% to -13% to +8% to -9%, and reporting can now be aggregated at the practice level instead of the individual nephrologist level.
- ▶ **New ICD-10 codes created for CKD 3A-3B, C3GN**
 - The addition of these diagnosis codes will enhance the identification of kidney disease and will delineate C3GN from dense deposit disease.
- ▶ **CMS implemented G-codes for pAVF creation**
 - These services were payable for facility charges in ambulatory surgical centers (ASCs) but not billable by physicians; this change allows for reimbursement to physicians for pAVF creation.
- ▶ **HHS Workgroup adopted RPA telehealth recommendations**
 - The workgroup recommended permanently eliminating originating site and geographic restrictions.

- ▶ **CMS truncated time period used in ESRD PPS to determine rate-setting for calcimimetics**
 - CMS reduced the interval by which the payment rate for calcimimetics will be calculated from two years to 18 months; RPA called for the data collection period to be for one year.
- ▶ **CPT approved codes for COVID testing, PPE practice expense**
 - If implemented by Medicare and other payers, COVID testing and PPE payment would be provided. RPA and all of organized medicine are currently advocating for Medicare coverage of these expenses.

Your support of RPA enables the association to advocate on behalf of nephrology practice and kidney patient care. For more information about RPA's public policy activities, contact Robert Blaser at rblaser@renalmd.org. ★ ♦

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From Capitol Hill

from page 1

Electioneering before November 3 pretty much scotched the possibility of anything meaningful occurring legislatively prior to that date, and the perceived and/or manufactured uncertainty about the presidential election result did not facilitate cooperation on what needed to happen. However, once the Electoral College certified the outcome on December 14 and leading Republicans began to recognize Mr. Biden as the President-Elect, the logjam on an agreement was broken and things came together pretty quickly. The deal was announced the evening of Sunday, December 20th, so we were all good for the Christmas holiday, right? Per the words of Lee Corso, ESPN College Football Gameday commentator, “Not so fast my friend.” The evening of December 22nd, Mr. Trump released a video decrying the deal as an “embarrassment,” calling for the payout to individuals to be \$2,000 instead of \$600, and saying he wouldn’t sign it. This was despite him personally being not involved in any of the negotiations, his representatives signing off on the deal (with the \$600 figure reportedly being their idea) and it passing with large margins including a majority of Republicans. Fortunately, rationality prevailed five days later, and the President signed the bill on December 28.

As noted, the package included the immunosuppressive drug coverage bill, and this of course is a major and long-awaited victory for the kidney community. The coverage period begins on January 1, 2023, so it is delayed, but this is likely in order to allow CMS to go through rulemaking on how to implement the expanded benefit. Once it was apparent that there wouldn’t be a stopgap (i.e., very short) spending bill, enactment of the immuno provision was all but a fait accompli, nevertheless, it is a tremendous accomplishment. Expanded immunosuppressive drug coverage has been an RPA legislative priority for over ten years, and on our policy radar for years before that, so this is a huge success for the organization.

The more interesting story is what occurred with physician reimbursement and the Medicare Fee Schedule conversion factor (CF). Recall that when the 2021 MFS proposed rule came out in August, it included substantial increases for E&M codes and the outpatient dialysis code family, and created a complexity modifier for E&M services that accounted for the extra work and practice expense associated with highly complex patients (and which could likely be applied to most CKD patients). This tremendous news was offset, however, by the reality that, in a budget-neutral system like Medicare, that money has to come from somewhere, which led to an approximate 11% reduction in the CF. A cut of this nature of course affects all Medicare providers, and so most of the surgical/procedural community, as well as groups representing radiologists and physical therapists, lobbied as hard as any time in recent memory on any issue to get the CF cut reversed. A simple fix for this would have been to take the funds out of the COVID-related Medicare provider relief funds at a supposed \$7 billion cost. This was put into a draft bill sponsored by Rep. Michael Burgess, MD (R-TX). However, this fix was opposed by many Hill policymakers, as it was feared that it would recreate the yearly problem that the sustainable growth rate (SGR) posed until it was resolved in 2015.

Another alternative was the bill proposed by Reps. Ami Bera, MD (D-CA) and Larry Bucshon, MD (R-IN) that would have provided two years of relief from the CF cut but would have paid for it by reversing the increases in value for the E&M, dialysis, vaccinations, and other services increased in the 2021 MFS rulemaking and restoring the CF to its 2020 level. This was ostensibly being pursued to shield physician practices from such hits happening during a public health emergency (PHE), but the two-year timeframe seemed to belie the PHE as a justification. Indeed, political intelligence obtained

on this point had Hill staff indicating that an additional (primary?) rationale for the procedural societies seeking a two-year fix was to undo the wins that primary care and internal medicine had won at the RUC table (seemingly fair and square) in revaluing the E&M codes (and while the dialysis code family would be caught up in this too, those changes were administratively made by CMS and not by the RUC). Finally, there was a thought that Congress might do nothing and allow all of the revaluations and the CF cut to go forward, as there was word that the Senate in particular did not want to put big money into the MFS.

In the end, Congress kind of split the difference, adding \$3 billion to the fee schedule, delaying the implementation of the complexity modifier for three years (reportedly worth about \$3 billion as well), and leaving the RVUs in the fee schedule untouched. This is probably the best result that could have been hoped for by internal medicine and nephrology, as all of our value increases remain and the additional available funds should in the end reduce the CF cut from the proposed (and finalized, by the way) ~10% cut to 3.3% (this was announced on January 5).

Other highlights of the bill include a freeze on the AAPM thresholds for two years, which should allow more physician practices to qualify for the 5% AAPM bonus, significant additional funding for NIH, a surprise billing fix that is more favorable to physicians than insurers, and \$3 billion in additional grants for hospital and health care providers including physicians to be reimbursed for health care related expenses or lost revenue directly attributable to the PHE.

Moving forward, as we all know, Democrats now have control of the Senate, barely, based on the wins in Georgia by Senators Raphael Warnock and Jon Ossoff making the Senate 50-50, with ties

broken by Vice-President Kamala Harris. In fact, the margin is so tight that when new President pro tempore (essentially the ‘president’ of the Senate) Senator Patrick Leahy (D-VT) went to the hospital with back spasms on January 26, the precariousness of the Democrats’ situation was highlighted. However, for now, they do have control, allowing them to set the agenda and providing them with committee chairmanships and the ability to approve President Biden’s Cabinet nominees and federal judges on a party-line basis. With the House also in Democratic control, there is a path for that party’s priorities in conjunction with the Biden Administration to proceed toward enactment/implementation, but it is a narrow path.

On kidney issues specifically, while admittedly not a legislative concern, a major policy question is whether the presence of a new administration will affect the pursuit of the Advancing American Kidney Health (AAKH) initiative. For now, the jury is still out. The nominee for the Department of Health and Human Services (HHS) Secretary, Xavier Becerra (former California Attorney General and member of the House), at press time had not even had a confirmation hearing scheduled, and his road to approval seems challenging. Further, CMS has an Acting Administrator, Elizabeth Richter (formerly of the CMS Ambulatory Payment Division), and the conventional wisdom is that major policy changes do not often occur under acting leadership. All of which is to say that absent something unexpected, there is not much on the horizon that would undo AAKH.

Back to the Hill, RPA’s 2021 legislative priorities (living organ donation, omnibus kidney legislation, and telehealth legislation) are outlined in detail on page 7, and the 2021 RPA Virtual Capitol Hill Day is scheduled for May 21. Please join us that day in petitioning your elected leaders in advancing the issues on our advocacy agenda. Presumably by that time, doing the people’s business (even virtually) will have returned to normal. Best wishes for a healthy springtime. ♦



RPA Thanks Outgoing Board Members

RPA members voted on a new slate of Board members who will begin their terms this month. The new members will be featured in the May issue of *RPA News*. In this issue, the association leadership and staff recognize the contributions of the outgoing board members who have volunteered numerous hours of service to move RPA and the nephrology specialty forward. We are grateful for the time they have taken from their professional and personal lives and given to their professional society. RPA could not succeed without their dedication and commitment.



Dr. Robert Fuld feels privileged to have contributed to the strategic planning sessions during which the leadership has charted a positive direction for the RPA. “The Board recognizes that in order for nephrologists to do what’s best for our patients we must successfully affect policies and business management practices. If we do what’s right for kidney patients, everything else will follow,” he explained. “RPA is at the forefront fighting for appropriate coverage for medications and therapies for patients and reducing barriers to

access to care. It was so rewarding to see that after so many years of participating in Capitol Hill Days and advocacy with Maryland’s Congressional delegation that legislation extending coverage for immunosuppressive drugs was passed at the end of last year—finally!”

As a member of the Board, Dr. Fuld benefitted from participating in discussions with colleagues around the country and hearing diverse perspectives around important issues affecting the specialty. “I was able to share these insights on critical issues with colleagues in my practice to better position us for changes in regulations, reimbursement, and legislation. It’s been a difficult year for all of us but I’ve really missed the in-person Board meetings where we can informally engage with one another. Although I am rotating off the Board, I look forward to remaining actively involved in RPA. Serving on the Board has shown me that RPA has the right approach to impacting nephrology care. I sleep better at night because I know I had a part in doing what’s right for kidney care.”



“Although my entry onto the Board was just after I had retired from many years of bedside practice, I hope that I have contributed to the priorities and activities of the organization to help others in their nephrology practices based on my experiences,” noted **Dr. Robert Kenney**. “Without a doubt, I believe my greatest contribution to RPA and nephrology was as chair of the Healthcare Payment Committee during my Board term, specifically leading a workgroup that developed an Alternative Payment Model Proposal

that was presented and approved unanimously for implementation by the Physician Technical Advisory Committee (PTAC) in December 2017. That model contained some novel ideas, including a financial incentive to the nephrologist for pre-emptive or early dialysis transplantations, which is one element of the CMMI alternate payment models now underway.”

As an RPA member since 1988, Dr. Kenney found his experience joining the Board quite comfortable since he already had developed relationships with many of his fellow Board members over the years, including some longtime friends. “In other organizations, people may serve in leadership roles for a while and then drop off; however, with RPA, most of us are in it for the long haul. Before I became a Board member, RPA impacted my nephrology practice in Baton Rouge. We were quick to adapt to changes in documentation, billing and coding, use of physician extenders, and other strategies in order to make our practice successful and not have to always rework things. I was involved

with NCAP (now PAL) since its inception, and that clearly impacted practices before the Medicare Administrative Contractors (MACs) when there were many more Medicare Carriers, thus allowing us to communicate and problem-solve issues experienced in certain locales.”

Dr. Kenney acknowledged that young nephrologists, by necessity, are quite busy not only building their practices but raising families. There isn’t always an appreciation for the business aspects of practice or the regulatory environment that governs much of what nephrologists do. “The older individuals are not always going to be around to do things to help the practice. So there is the rationale for involvement in RPA and, as time passes, the opportunity to share experiences in leadership opportunities, such as Board service,” Dr. Kenney reflected. “We learn nephrology first as a beginner, then novice, then intermediate, then expert. But it is only in understanding and becoming involved in all aspects of nephrology, the science, the practice adaptations, the business activities to remain successful, and leading in terms of influence in regulatory oversight that one truly masters his/her life’s work.”



Dr. Rebecca Schmidt got involved in RPA when another past president and fellow West Virginian Dr. Derrick Latos invited her to attend an NCAP meeting. “I have learned so much from those who have preceded me. I remember meeting Dr. Chaim Charytan at that first NCAP meeting who graciously exposed me to everything I didn’t know, which was a lot! Subsequently, Dr. Bob Provenzano asked me to chair the Healthcare Payment Committee where I worked with Dr. Mike Germain on EPO issues and hospice coverage for ESRD,” Dr. Schmidt reflected.

“Serving as an RPA Board member and President offered me so many opportunities to visit Capitol Hill to educate and enlighten politicians (more often their staffers) about the ravages of kidney disease and how it impacts a patient’s life, even though it is not “sexy” like heart disease. Obtaining coverage for care for dialysis for patients with acute kidney injury (AKI) so long in coming felt like a huge triumph.”

Dr. Schmidt acknowledged the joy she has experienced working with colleagues who care about patients and her gratitude for the enduring friendships that were created through her Board service.

After 14 years of service as a member of the Board of Directors, Dr. Schmidt noted, “I will miss being with everyone connected to RPA (both old and new), but it is time for others to lead, manage, and serve. I hope to stay involved peripherally if and when RPA needs me and/or I can serve. I will miss working on papers and communications; it was always exciting to develop RPA’s message. But I am excited to become one of the RPA Past Presidents, a group of individuals I have always greatly admired for their depth of commitment to RPA and their patients.”

As an RPA delegate to the American Medical Association, Dr. Schmidt will continue to remain engaged with the association. “There is a great opportunity for networking across medical specialty societies, and I hope that I can help share RPA’s mission, vision, and successes following in the footsteps of another RPA past president and mentor, Dr. Lou Diamond.”

She offered her advice to the next generation of nephrologists. “Our profession needs the inspiration, vigor, and passion of our early career nephrologists. Involvement in advocacy and public policy via RPA gives all of us (and particularly the early career nephrologist) a professional outlet that is distinct from one’s ‘day job,’ but vital to one’s career. It will give you a perspective like no other and more opportunities than could be imagined as well as a network of colleagues and friends that will endure. Finally, leadership is not just needed – it is vital to the future of our profession, and the early career nephrologist is at the forefront of leading the profession to future success.” ♦

2021 ESRD PPS Rule’s Efforts to Promote Innovation Face Challenges

In November 2020, CMS issued the final rule for the 2021 End-Stage Renal Disease Prospective Payment System (ESRD PPS). To level-set, the PPS is the method by which Medicare determines annual reimbursement to dialysis facilities for the services provided to their patients who are Medicare beneficiaries. Its existence was a policy victory for the kidney community. Prior to 2011, there was no annual ESRD payment system update, and Congress actually had to pass a new law to adjust the payment levels for dialysis facility services each year. Because Congress often moved Medicare legislation only once every two years, the dialysis updates generally happened every other year and were a fraction of what the market basket would have provided. However, this situation changed with the enactment of the Medicare Improvements for Patients and Providers Act (MIPPA) in 2008 establishing the PPS and an annual update mechanism, with CMS rulemaking occurring in 2010 for 2011 implementation. Thus, revision and updating of the ESRD PPS now happens automatically and does not require Congressional action.

As for the 2021 rule, the headline news each year is where the base rate for the PPS payment will be set. This year, it is set at \$253.13, for both home and in-center dialysis and for AKI services; by law, as of 2015, the AKI rate must be equal to that for in-center patients. The \$253.13 figure was a sizable \$13.80 increase in the base rate over the 2020 amount of \$239.33, with a large portion of the increase being due to the inclusion of calcimimetics in the 2021 PPS (more on calcimimetics later). Other issues affecting the base rate are the annual wage index budget neutrality adjustment (typically a slightly negative downward adjustment; this year the figure is .999485) and a legislatively required market basket increase minus the productivity factor and sequestration (when it is not paused by Congress), which this year is 1.6%. Additionally, CMS annually adjusts the bundled payment using patient-specific “case-mix adjustments” such as patient age, body surface area (BSA), low body mass index (BMI), comorbidities, the onset of dialysis, and age and modality type for pediatric patients. The final adjustment to the rate is for facility-level adjustments, including a low-volume adjuster and a rural adjuster.

In recent years, there have been efforts to promote innovation in the PPS by creating programs that would provide additional funding for innovative products and services in the dialysis care arena. These are:

- (1) The Transitional Drug Add-on Payment Adjustment (TDAPA) is intended to provide reimbursement for new injectable or intravenous drugs or biologicals used for the treatment of ESRD. There are three variations of TDAPA. The first applies to drugs that were oral-only and then an IV form comes to market. This TDAPA applied to the calcimimetics. The second is for drugs or biologicals that would come within an existing functional category. These products also receive TDAPA, but only for two years and only at ASP+0%. Once the TDAPA period ends, the bundle rate is not adjusted to account for the new product. The third variation is for products for which there is no current functional category. These products would receive TDAPA for two years at ASP+0%, but then CMS will adjust the bundled rate and create a new functional category when they are added to the bundle. (The first TDAPA became effective January 1, 2018.)
- (2) The Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES) applies to certain new and innovative renal dialysis equipment or supplies furnished by ESRD facilities and provides a two-year add-on equal to 65% of the MAC determined pricing. There is also a variation that provides this add-on for capital-related home dialysis machine assets. (effective January 1, 2020).

Developing an effective means of promoting innovation in the ESRD PPS would be a godsend to dialysis care in the U.S., as the degree of private investment in dialysis has been almost non-existent relative to other conditions and disease states. This lack of innovation is a result of the fact that the ESRD payment system, unlike hospital and other payment systems, has never had a mechanism for recognizing innovative products; absent some sort of innovation adjuster or

pathway, there is no upward payment adjustment to permanently account for the use new drugs or technologies in dialysis care. As a result, the incentives for the investment community to support the advancement of dialysis care are minimal, despite the tremendous opportunity for progress benefitting patient care in this area. So, while the creation of TDAPA and TPNIES is laudable, without a pathway to update the base rate when innovative products are added there is not an effective incentive (or arguably even possible) to adopt innovation long-term, so the broader goal of providing incentives for investment by the financial community to facilitate innovation as has occurred in other health care delivery sectors has not been realized. The long-term pathway is particularly important given the historically low and even negative margins that the Medicare Payment Advisory Commission has found in its analyses of Medicare dialysis rates.

How these issues manifested themselves in the 2021 PPS final rule is illustrative. Calcimimetics were included in the 2021 base rate for the first time, and as a result, the per treatment payment increased by \$9.93. Such an increase is certainly positive, but there are methodological concerns with how CMS arrived at this figure. In the proposed rule for 2021, CMS solicited comment on the duration of the calculation period used to determine the payment for calcimimetics, specifically whether the Agency should instead use a single calendar year (CY 2018 or CY 2019) rather than both CYs 2018 and 2019 in its methodology. RPA, along with other groups in the kidney community, called for CMS to not use 2018, with RPA’s comments stating:

Given that CMS only began paying for calcimimetics under the ESRD PPS using the transitional drug add-on payment adjustment (TDAPA) on January 1, 2018, utilization data for 2018 will be distorted by the incremental adoption of these products by some providers and facilities, as well as the development, implementation, and evolution of protocols for their use occurring during 2018.

In the final rule, CMS did not exclude the CY 2018 data altogether, opting instead to utilize the last two quarters of 2018 through 2019 and thus to base the rate on 18 months of data. RPA and others urged CMS to use the most recent data possible on which to base the calcimimetics payment, for example, to even use the first quarter CY 2020 data that would clearly help minimize the incremental adoption concerns, but CMS declined to adopt this recommendation. So, while CMS did provide a healthy increase in the base rate to account for the calcimimetics payment, some in the kidney policy community believed it to be a less than optimal data period. Further, it is worth reiterating that CMS has not adopted the recommendation of the community, including RPA, for a three-year TDAPA and TPNIES period, which would align the policy with the outpatient pass-through payment for drugs and biologicals and allow for a full two years of experience with a product to assess whether or not new money should be added to the base rate to support long-term adoption.

With regard to how TPNIES was handled in the 2021 rulemaking cycle, a noteworthy change was that CMS expanded the eligibility for certain capital-related assets including home dialysis machines when used in the home for a single patient. Further, MACs are now obligated to, in essence, follow this policy change (explicitly curtailing the MACs usual policy making autonomy in this specific instance). While this definitely represents an expansion of the TPNIES policy, there paradoxically will not be any actual application of the policy for 2021, because neither of the two products under consideration for coverage in the TPNIES program (a dialyzer and a cartridge for a home dialysis machine) were determined by CMS to have met the eligibility criteria for TPNIES for CY 2021. In fairness to the Agency, these may have been the correct decisions to make in these specific instances, but they are also indicative of the impediments associated with revising the PPS to reflect the current state of available therapeutics.

Accordingly, RPA’s comments on the 2021 ESRD PPS proposed rule addressed CMS’ efforts to promote innovation broadly. Specifically, RPA urged the Agency to:

- (1) use a three-year window for TDAPA and TPNIES add-on payments instead of the current two-year interval;

- (2) identify processes to upwardly adjust the ESRD PPS base rate when an innovative drug, item of equipment, or supply is acknowledged to truly improve patient care, without requiring corresponding budget neutrality; and
- (3) provide flexibility in evaluating new drugs and products such that the bar to clear in introducing a new therapeutic innovation into the bundle is not so high as to deter research and development advancements, while still accounting for the need to demonstrate clinically significant improvement, considering the needs of pediatric patients as well as those of adults.

In summary, the history of the Medicare payment system for dialysis facilities is marked by some steps forward and some steps back (or

at least sideways). The creation of the PPS in 2011 was a great step forward, but the intransigent nature of the bundle has since stifled innovation. Development of the TDAPA and TPNIES programs represented progress in the effort to bring new products “to market” in dialysis, but methodological processes such as the correct time period upon which to base a calculation or the eligibility criteria for a new product can be barriers to bringing the ESRD PPS into the 21st century. Implementation of a policy change creating some sort of innovation payment adjuster in the PPS and sufficient funding to support long-term adoption of such innovation, which is all but certainly only possible through legislation, is necessary to update the dialysis payment system appropriately. ♦

RPA Sets 2021 Legislative Agenda

During its January meeting, the RPA Board of Directors finalized RPA’s legislative agenda for 2021, approving a slate of recommendations made by the RPA Government Affairs Committee (GAC) that include the following issues of consequence for kidney care and nephrology.

- ▶ **Codification of improvements in and further enhancement of living organ donation.**
- ▶ **Enactment of legislation that permanently eliminates the originating site and geographic restrictions on the use of telehealth in the U.S.**
- ▶ **Omnibus kidney disease legislation.**

The expectation is that the living organ donation bill will be virtually identical to previous iterations, which: (1) designated living organ donation as a serious health condition for the purposes of the Family Medical Leave Act (FMLA); (2) prohibited the denial of insurance coverage or the raising of insurance rates based on living organ donation; and (3) required HHS to develop new educational materials on living organ donation. While the Department of Labor issued an advisory opinion several years ago indicating that they considered living organ donation as a serious health for FMLA purposes, the bill would codify this into law.

On telehealth, legislation was introduced in early 2021 that would make permanent the elimination of the originating site and geographic restrictions that vastly limited the use of telehealth prior to the PHE. This bill, HR 366, the Ensuring Telehealth Expansion Act of 2021, has broad bipartisan support and is expected to be the starting point for telehealth changes in the 117th Congress.

The omnibus kidney community bill is developed every year by Kidney Care Partners (KCP), which is a coalition representing health professionals, patients, dialysis providers, and pharmaceutical companies, and of which RPA is a member. This legislation will never likely get enacted as a stand-alone bill itself but generally is intended to serve as a platform from which worthwhile individual provisions can be selected for inclusion in bigger bills. This strategy has resulted

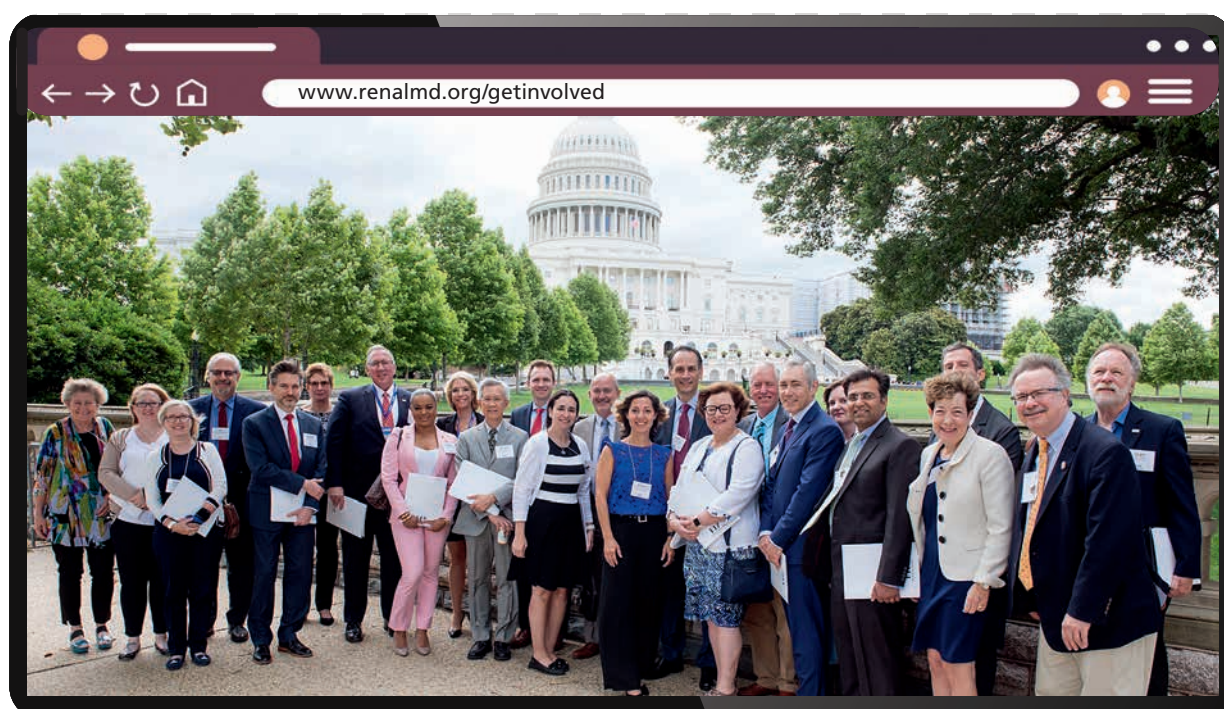
in provisions such as coverage for outpatient AKI dialysis outside of a hospital and access to Medicare Advantage for all ESRD patients being included in other bills.

The 2021 kidney community/KCP-led bill includes the following provisions:

- Expand Medicare Annual Wellness benefit to include kidney disease screening;
- Expand the Kidney Disease Education (KDE) program by including access to stage V patients who are already Medicare beneficiaries and allowing providers/suppliers permitted to bill for KDE services to include physician assistants, nurse practitioners, and clinical nurse specialists;
- Promote innovation by providing CMS with authority to establish a sustainable pathway for innovation;
- Expand Medigap policy;
- Extend Medicare Secondary Payer (MSP);
- Require HHS to include outpatient dialysis services in the Network Adequacy Standards; and
- Modernize the ESRD QIP and Five Star programs.

While not all of the above issues in the community bill are of high priority to RPA, facilitation of kidney disease screening, expansion of the KDE benefit, and promoting innovation in kidney care are all worthy objectives.

Please make plans now to join the RPA community virtually for RPA’s Annual Capitol Hill Day on May 21. Lend your voice to these important issues and advocate with your elected officials for much-needed changes to improve your practice and kidney care. RPA schedules these meetings and provides background information, but we need you to tell your stories about real-world experiences. Watch your email and the RPA website for registration information. (There is no cost to participate.) ★♦



Legal Issues: Dialysis Patient Citizens, Dialysis Providers Challenge Medicare Advantage Network Adequacy Requirements

By Kimberly Kannensohn and Nesko Radovic



Since the early 1970s, the Medicare program has provided coverage to an individual diagnosed with ESRD, with reimbursement on a fee-for-service basis, i.e., through “Original Medicare.” However, until recently, a patient newly diagnosed with ESRD could not receive coverage through a Medicare Advantage (MA) plan, unless the patient was already enrolled in an MA plan at the time of the ESRD diagnosis.

This long-standing limitation was eliminated with the passage in 2016 of the 21st Century Cures Act (the “Cures Act”). Pub. L. No. 114-255, 130 Stat. 1033 (2016). The Cures Act provides that, as of January 1, 2021, ESRD patients have access to MA plans in a manner akin to all other Medicare beneficiaries. Pub. L. No. 114-255, § 17006, 130 Stat. 1033, 1334-36.

CMS Removes Dialysis Facilities From the MA Network Adequacy Requirements Related to Time and Distance

In February 2020, CMS promulgated a proposed rule and, on June 2, 2020, CMS issued a final rule implementing the relevant provisions of the Cures Act. CMS: *Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program*, 85 Fed. Reg. 33796 (June 2, 2020) (the “Final Rule”). In the Final Rule, CMS removed outpatient dialysis facilities from the network adequacy standards imposed upon MA plans related to time and distance, replacing the requirements with an attestation. 85 Fed. Reg. 33796 at 33853. These requirements mandate that a network provider be located within a certain travel time and distance of covered beneficiaries, with the time and distance requirements varying based upon the provider’s specialty or geographic location.

“The Cures Act provides that, as of January 1, 2021, ESRD patients have access to MA plans in a manner akin to all other Medicare beneficiaries.”

Initially, CMS used a “rough benchmark” that required providers to be located within approximately 30 minutes or 30 miles of enrollees. CMS: *Medicare Program; Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs*; Proposed Rule, 74 Fed. Reg. 54634, 54644–45 (Oct. 22, 2009). However, CMS determined that it needed to “explicitly define . . . more specific criteria” for assessing network adequacy. *Id.* at 54644–45. To that end, CMS adopted the time and distance requirements as part of its criteria designed to simplify health services delivery (HSD) submissions in 2010, in order to “increase the consistency and transparency of network reviews,” CMS: *Medicare Program; Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs*, Final Rule, 75 Fed. Reg. 19678, 19684 (April 15, 2010). CMS subsequently explained that its prior criteria “lacked concise and standardized definitions of an ‘appropriate’ and ‘adequate’ network.” CMS, *Contract Year 2012 Medicare Advantage Health Delivery Guidance*, at 1.

“The complaint alleged that CMS’ elimination of the network adequacy requirements related to time and distance in the Final Rule effectively invalidated the new MA coverage mandate under the Cures Act.”

During a network adequacy review, “Medicare Advantage organizations must demonstrate that their networks do not unduly burden beneficiaries in terms of travel distance and time to network providers/facilities.” CMS, *Medicare Advantage and Section 1876 Cost Plan Network Agency Guidance*, at 10 (Feb. 2018). The maximum travel and distance requirements obligated Medicare Advantage plan applicants to demonstrate that 90% of their beneficiaries have access to at least one provider/facility, in each specialty type, within established time and distance requirements. Since 2011, when this rule became effective, outpatient dialysis facilities have been among the facilities covered by these standards.

MA plans contract with CMS on a county-by-county basis and are responsible to attest that the plan has an adequate network of contracted providers within each county to provide beneficiary access to care. The table below provides examples of the time and distance requirements from the beneficiary’s home or workplace to their dialysis provider that MA plans were required to meet, as set forth in the 2019 HSD reference file, with only 41 counties in the United States exceeding these requirements.¹

Type of County	Maximum Time	Maximum Distance
Large Metro	20 minutes	10 miles
Metro	45 minutes	30 miles
Rural	60 minutes	50 miles
Micro	100 minutes	90 miles

Dialysis Patient Citizens and Dialysis Providers Seeks Judicial Recourse

On June 22, 2020, Dialysis Patient Citizens (DPC) filed suit in the United States District Court for the District of Columbia against HHS. *Dialysis Patient Citizens, et al. v. Alex M. Azar II, Secretary of Health and Human Services*, No. 20-CV-1664 (TSC), 2021 WL 184318 (D.D.C. Jan. 19, 2021). DaVita Inc. (DaVita), Fresenius Medical Care Holdings, Inc. d/b/a Fresenius Medical Care North America (Fresenius), and U.S. Renal Care, Inc. (U.S. Renal Care) joined the action as named plaintiffs. The complaint alleged that CMS’ elimination of the network adequacy requirements related to time and distance in the Final Rule effectively invalidated the new MA coverage mandate under the Cures Act. Specifically, the plaintiffs argued that by removing these requirements, HHS created a circumstance in which patients seeking to enroll in MA plans may not be within a reasonable driving or commuting distance of the dialysis facility in their network.

HHS moved to dismiss the plaintiffs’ complaint, and the parties filed cross motions for summary judgment. On October 23, 2020, RPA filed an amicus brief in support of the plaintiffs’ motion for summary judgment, and in opposition to HHS’ motions. In its brief, RPA noted that elimination of the time and distance requirements could have a significant detrimental effect on dialysis patients, including reduced attendance, missed dialysis treatments, diminished quality of life and increased mortality.

1 2019 HSD reference file is available at https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/HSD_2019_Reference_File_2018-08-01.xlsx

On December 31, 2020, HHS filed a supplement to its pending motions (the “Supplement”). The Supplement related to the contention by the provider plaintiffs (i.e., DaVita, Fresenius and U.S. Renal Care) that they had suffered an injury as a result of the Final Rule and thus had standing to participate in the lawsuit. In the filing, HHS asserted that DaVita claimed it had suffered an injury as a result of the elimination of the network adequacy requirements related to time and distance, because Humana was dropping DaVita from its MA network for the 2021 plan year. However, on December 23, 2020, CMS was informed that Humana had reached an agreement with DaVita and that DaVita would remain as an in-network provider with Humana for the 2021 plan year. In other words, from HHS’ perspective, DaVita had not suffered an injury related to the rule change because they were able to secure a contract with Humana.

On January 14, 2021, the plaintiffs filed a response to HHS’ supplement in which the plaintiffs acknowledged DaVita’s contract with Humana. The plaintiffs asserted, however, that HHS was incorrect in its assertion that plaintiffs suffered no injury, and thus have no

“In its brief, RPA noted that elimination of the time and distance requirements could have a significant detrimental effect on dialysis patients, including reduced attendance, missed dialysis treatments, diminished quality of life and increased mortality.”

standing to bring the lawsuit. Specifically, the plaintiffs alleged that Humana’s conduct hurt DaVita and its patients because, during open enrollment in MA plans, i.e., between October 15, 2020 and December 7, 2020, Humana announced that it was not renewing its contract with DaVita as an in-network provider. According to the plaintiffs, this announcement discouraged patients dialyzing at DaVita facilities from enrolling in MA plans. The plaintiffs also argued that Humana’s conduct hurt DaVita by potentially discouraging patients interested in the Humana MA plans from dialyzing at DaVita facilities and depriving DaVita of the higher reimbursement rates under the MA plan.

On January 15, 2021, the court issued an order striking both of these pleadings, explaining that it typically accepts only three memoranda on a single motion, supplemental memoranda are disfavored, and neither party asked the court for permission to file the supplemental briefs.

The District Court Grants HHS’ Motion to Dismiss

On January 18, 2021, the district court issued a memorandum opinion and an order granting HHS’ motion to dismiss, without prejudice, and denying each of the other pending motions. The order was granted on the grounds that the plaintiffs’ claims are not ripe for adjudication.

In their Motion to Dismiss, defendants argued that the plaintiffs’ complaint failed in three respects:

- i. Defendants argued that the plaintiffs failed to allege that delaying judicial review would cause significant hardship. Defendants argued that the record contains no evidence that the Final Rule has caused or imminently will cause the plaintiffs any hardship, nor does it show that the Final Rule has prevented patients of the plaintiffs from receiving adequate care.
- ii. Defendants also argued that judicial review at this stage would improperly interfere with the administrative appeals process, and that plaintiffs must exhaust their administrative remedies through HHS’ established appeals process before filing suit in court.
- iii. Finally, defendants argued that plaintiffs’ claims were unripe and were in need of further factual development. Defendants argued that a challenge that made its way through the administrative appeals process could show that the Final Rule caused an MA organization to drop outpatient dialysis facilities from their plans in a manner that improperly limits access to dialysis services for beneficiaries who need them. Alternatively, defendants argued, an administrative process might show that the Final Rule spurred innovation and cost savings in a highly concentrated market without negatively affecting either defendants or the Medicare program.

In its memorandum opinion, the Court indicated that, because the plaintiffs did not timely respond to the defendant’s ripeness arguments, the Court treats those arguments as conceded by plaintiffs. Accordingly, the Court granted the defendant’s motion to dismiss on the grounds that the claims are not yet ripe for adjudication and did not address the arguments related to standing. However, the Court cautioned the parties that if the action comes back before the court, certain threshold questions, including ripeness and standing, will need to be addressed appropriately in the parties’ briefs.

As the Court’s order was granted without prejudice, DPC and the dialysis provider plaintiffs are not barred from filing a new complaint against HHS related to the Final Rule. However, to survive a motion to dismiss, they will need to establish that they have standing, that their claims are properly before the court, and that they will suffer hardship if their claims are not considered by the court. ♦

Ms. Kannensohn is a partner in the McGuireWoods Healthcare Practice and counsel to the Renal Physicians Association. Nesko Radovic is an associate in the McGuireWoods Healthcare Practice.

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Share Your Experiences with 2021 Medicare Advantage Plans

In May of 2020, CMS issued a final rule outlining requirements for Medicare Advantage plans for 2021. The rule is significant to the kidney community since 2021 is the first year that Medicare-eligible ESRD patients can enroll in MA plans for their Medicare coverage regardless of previous insurance status, as mandated by the 21st Century Cures Act (Cures Act).

The final rule was a catalyst for several concerns affecting nephrology. The first is regarding the narrowing of provider networks, as RPA received reports from the field that MA plans in some states were vastly reducing the number of in-network nephrologists for that state—in one, over 75% of the nephrologists did not have their contracts renewed for 2021. Secondly, the final rule eliminated the use of time and distance standards specifically regarding coverage for ESRD (dialysis) patients in MA plans. CMS finalized a policy in the MA rule that the time and

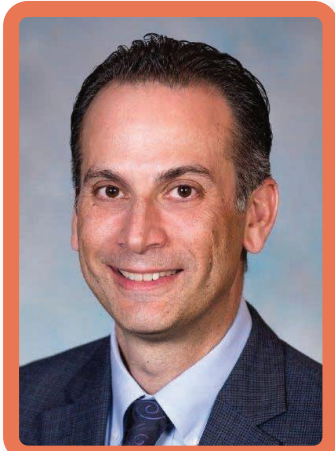
distance standards weren’t necessary for dialysis patients due to the availability of home dialysis modalities. In fact, in late October, RPA also filed an amicus curia brief in support of a lawsuit against HHS on the MA final rule based on these and similar concerns (the lawsuit was dismissed in early January).

RPA seeks feedback from nephrologists to understand whether and how the 2021 Medicare Advantage rule is affecting nephrology practices and the care nephrologists provide to kidney patients. For example, are there any barriers to care due to narrower networks and/or the elimination of time and distance standards? Please contact RPA Director of Public Policy Rob Blaser at rblaser@renalmd.org to share your experiences and observations, positive or negative, that could help shape potential RPA policy development in this area. ♦

VIRTUAL 2021 RPA ANNUAL

Same Unique Content, Different Format

By Gary Singer, MD, Chair, Education Committee



The RPA remains committed to empowering nephrology professionals. The past year has been very challenging for our patients and the entire kidney care team. Due to the COVID-19 pandemic, last year's annual meeting was cancelled, and this year's meeting will be virtual. While I was looking forward to catching up with old friends and meeting new people, the format of the 2021 annual meeting will allow for greater participation and increased engagement.

I am excited to announce we are kicking off this year's meeting with a session on social media, specifically focusing on Twitter for nephrologists, or #NephTwitter. We are also focusing on topics to help early-career nephrologists succeed in practice. There will be panels discussing new models of kidney disease care as well as addressing the social determinants of care of our patients.

The Louis Diamond Keynote Lecture will be delivered by Dr. Vivian Lee, who leads Verily Life Sciences' Health Platforms and is the author of *The Long Fix: Solving America's Health Care Crisis with Strategies That Work for Everyone*. She will discuss what a transition to a value-based system of health care delivery could mean for practitioners in the renal space, and what individuals can do to become advocates for change. She'll also offer examples of how patients, physicians, and providers can use technology to become co-producers of health. (see sidebar)

While we will not join together to break bread at an AAKP Dinner this year, we are honored to have Kevin Fowler, a kidney transplant recipient, discuss strategies to engage our patients in their care.

The last day of the meeting will include clinical sessions with a special focus on novel therapies for diabetic kidney disease and the role of the nephrologist in caring for this growing patient population. We are thrilled to have Dr. Katherine Tuttle, co-author of the 2020 KDIGO Clinical Practice Guideline for Diabetes Management in CKD, deliver this address.

Even though we can't meet in person for a cup of coffee or a cocktail, we have incorporated Live Q&A, Meet the Speakers, and virtual Happy Hour sessions. I look forward to seeing everyone at #RPA21 – so login to Twitter (or sign up if you're not yet engaged) and help spread the news using the hashtag #RPA21. ☆◆

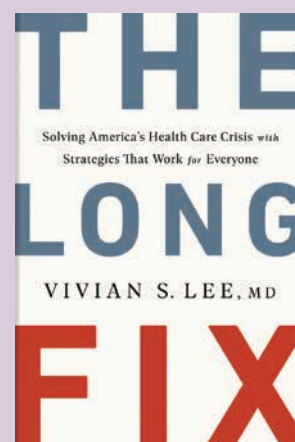
Louis Diamond Keynote Lecture



Vivian S. Lee, MD, PhD, MBA, is President of Health Platforms at Verily Life Sciences, an Alphabet company, whose mission is to apply digital solutions that enable people to enjoy healthier lives. A passionate champion of improving health in the U.S. and worldwide, she works closely with Verily's clinical and engineering teams to develop products and platforms that support

the successful transformation of health systems to value and advance the co-production of health with patients, their caregivers, and communities. In 2019, she was ranked #11 among the Most Influential People in Healthcare (**Modern Healthcare**). She is the author of the acclaimed book, **The Long Fix: Solving America's Health Care Crisis with Strategies that Work for Everyone** (Norton, 2020). Dr. Lee is an MR radiologist who developed novel methods for measuring kidney function and vascular disease with MRI. Funded by the NIH for 20 years, Dr. Lee was elected to the National Academy of Medicine (formerly, the Institute of Medicine) in 2015, and in 2019, she received the International Society for Magnetic Resonance in Medicine's highest award for scientific contributions and leadership, the Gold Medal.

Dr. Lee is a *magna cum laude* graduate of Harvard-Radcliffe Colleges, received a doctorate in medical engineering from Oxford University as a Rhodes Scholar, earned her MD with honors from Harvard Medical School, and was valedictorian of her Executive MBA program at NYU's Stern School of Business. ◆

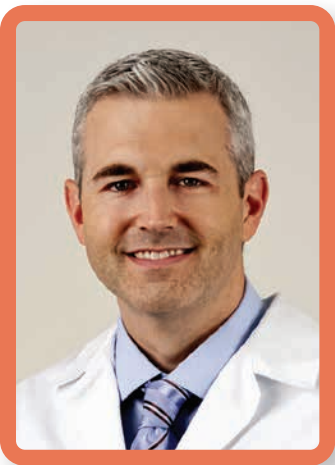




MEETING HIGHLIGHTS

Advancing Kidney Care Health

By Brendan Bowman, MD, Vice Chair, Education Committee



The AAKH Executive Order (EO) was announced in the summer of 2019. The goal of this EO is to improve access to home therapies, transplant and reduce care costs for Medicare beneficiaries. To accomplish this, AAKH creates new alternative payment models building on the ESCO experience, but also moving quality and performance metrics upstream into the CKD clinic.

Within the AAKH, two distinct programs were created – a set of voluntary models (Kidney Care Choices,

or KCC) and a mandatory model (ESRD Treatment Choices, or ETC). The latter will enroll approximately 30% of ESKD beneficiaries across the country. Despite being a year and a half from the initial announcement, major updates in these models were being finalized through the end of 2020.

This year’s RPA Annual Meeting features a raft of experts focused on making sense of these exciting but complex models. Providing overviews of the KCC and ETC models respectively are health policy expert and nephrologist Eugene Lin MD, MS, and health IT regulatory expert Diana Strubler. Following the overview, Chronic Disease Research Group and USRDS epidemiologist Eric Weinhandl, PhD, MS, will take a deeper dive into the ETC model. His talk will review the latest Medicare claims data used for ETC benchmarking and highlight regulatory pitfalls. If you still have questions, pitch them live to a panel of practice management, population health, and dialysis experts in an extended Q&A session moderated by RPA president-elect, Timothy Pflederer, MD.

Beyond regulatory changes, AAKH touches on a range of nephrology topics, including telehealth, transplantation, and home dialysis. Nationally recognized nephrology telemedicine expert Eric Wallace, MD, will provide an update on the latest relevant advances in telemedicine for nephrology practices. Home dialysis champion and RPA PAL Chair, Harry Giles, MD, will give a pragmatic talk on building and maintaining a successful home program. As important as building the infrastructure for success under AAKH, providers must learn to engage with patients and meet them “where they live.” Kevin Fowler, Principal at The Voice of the Patient Inc., and preemptive transplant recipient, will use his kidney disease journey to illustrate how to engage and empower patients with kidney disease.

Finally, changes are afoot in more than just the regulatory and payment fronts. Another annual meeting highlight will be the Disruptive Innovations in Healthcare panel moderated by Education Chair Gary Singer, MD. The panel will include three nephrology leaders providing their unique perspectives on changes in kidney care: Shika Pappoe MD, MPH, MBA and CMO of Strive Health, Carmen Peralta MD, MAS and CMO of Cricket Health, and Bruce Culleton MD, MBA and Vice President / CMO of CVS Kidney Care. Be sure to catch this panel for a preview of the future of care in nephrology. ♦

Building A Strong Foundation for Your Nephrology Career

By Samaya Anumudu, MD



The RPA annual meeting is a great venue for early-career physicians to network and learn fundamental skills and knowledge that will enable them to excel in their practice. This year, the RPA Education Committee is delighted to have sessions targeted specifically to early-career physicians and trainees with a diverse panel of speakers and sessions. These sessions highlight topics essential for all physicians, especially those early in their careers, to excel in practice. You will not want to miss these sessions, including

the Career Advancement Panel on March 18th for a live discussion and Q&A from experts in various areas of nephrology, including academic medicine, industry, interventional nephrology, transplantation, and research. Panelists include past and current presidents of national nephrology organizations, Women in Nephrology leaders, and fellow early career physicians and RPA members discussing lessons learned and tips for future success.

Panelists include:

Eleanor Lederer MD, FASN (Academic-Clinical Educator)
Professor of Medicine, University of Louisville

Nisha Bhatt MD (Industry)
Global Medical Affairs, AstraZeneca

Holly Kramer MD, MPH (Academic-Research)
Loyola University Chicago

Dapo Afolabi MD (Interventional)
Fort Worth Renal Group

Vishy Chaudhary MD (Transplant/ECP)
West Virginia University Medicine

There will also be sessions on Economics of Dialysis led by Dr. Irfan Agha which will cover the fundamentals of running a dialysis center, Practice Management 101 led by Dr. Paul Cespedes and Stacey Loomis to guide you in how to run a financially successful practice, and Contract Negotiations for individuals looking at both private practice and academic careers led by attorney Kimberly Kannensohn. These select sessions will be moderated by RPA early career physicians Samir Nangia MD, FASN, CPE and me, Samaya Anumudu, MD, both of whom serve on the RPA Education Committee.

These sessions will include dynamic speakers, interactive sessions, and Q&A for the best and most informative virtual experience possible, and will provide excellent networking opportunities for members. Importantly, these sessions and the annual meeting are FREE for RPA fellow members currently still in training. We look forward to having you join us this year! ♦





Value and Impact of Nephrology Advanced Practitioners

By Leah Foster Smith, MSN, APRN, FNP-BC, CNN-NP, FNKF



The role of the nephrology advanced practitioner (APs), which includes Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists, continues to grow across the country. Effective utilization of this AP role is vital to quality patient care and financial success of nephrology practices. This year’s RPA Annual Meeting will have multiple sessions to assist nephrology APs and practice leaders in better understanding the vitality and impact this role can have across nephrology settings, including

in-center and home hemodialysis, PD clinics, pre- and post-kidney transplant, outpatient clinics, education, research, and telemedicine. Sessions will also review AP scope of practice, billing practices, and professional development. As practices expand the number of nephrology APs in their practice, effective nephrology AP leadership becomes essential. APs who are interested in stepping into leadership roles in their practices will have the opportunity to explore how to develop these leadership roles, effective strategies in managing AP staff, ways to onboard and integrate new APs to the practice, and effectual techniques in retaining APs in nephrology practices long term. Come ready to learn, grow & leap into AP Leadership! ♦

Impact of Social Media (#SoMe) on Your Nephrology Career

By S. Sudha Mannemuddhu, MD, FAAP



Social media (#SoMe) has become an intricate part of our lives and has been embraced by the medical community, especially by nephrology. In addition to #SoMe’s value in professional development and social networking, it has become an important tool for supplementing and/or amplifying traditional medical education.

This year, the RPA education committee created a social media symposium catered to the needs of social media newbies. You will not want to miss these live discussions and Q&A session on March 18th, from #SoMe experts. The goal of these talks is to assist you in navigating social media and use it as an effective educational and networking tool.

Panelists include:

- Diana Mahbod, MD, @DiMiRenalMD – ‘Effective use of Twitter’
- Samira Farouk MD, MS, FASN, @ssfarouk – ‘FOAMed’-what’s all the hype
- Tony Breu, MD, @tony_breu – ‘Tweetorials 101’
- Joel Topf, MD, @kidney_boy – ‘Social media during Pandemic’

We look forward to having you join us this year! ♦

Expertise, Experience, Excellence for Practice Administrators

By Syd Stevens, CPC, CIMC, AAPC Fellow



In re-reading Stacy Loomis’ practice management column “A Year Like No Other” (January 2021 RPA News), I was reminded that nephrology managers have such a wonderful resource; our Renal Physicians Association. In the middle of the pandemic, I too sent questions to Mr. Rob Blaser and others and had them answered in a most timely and professional manner. I feel most comfortable sending an email to Dale or Rob and why? I’ve met them personally, through the wonderful RPA meetings!

I have also developed a network of wonderful nephrology colleagues through attending RPA meetings.

I’m old school and I like the personal interaction and “live experience” of the Annual meeting. At the outset of the pandemic, I was determined to dig in my heels and not become a “Zoomer.” I quickly found out I could not afford the luxury of “waiting until this was over.” Not with CKCC, ETC, changes to E/M Coding, Optimal CKD Care, and the push to home therapies looming. I decided to put on my big girl pants, dive into the deep end, and have embraced the Zoom. Several conveniences are offered through the virtual experience you may not have considered. The expense and time necessary to travel to an in-person meeting can be cost prohibitive for many smaller practices. Likewise, many practices – stretched at this point – cannot afford to have too many key players out of the office.

Let us look at the great education your RPA has prepared especially for practice managers:

- **Practice Finance Tools** with David Fisher, MBA – David’s approach is easy and not intimidating.

- **New Payment Models** with Terry Ketchersid, MD – Terry can explain the alphabet soup to help you make sense of it all.
- **Practice Administrator Round Table – Live Zoom Meeting** – One of the best reasons to attend! Here’s where you can meet wonderful colleagues and gain insight from others in practices just like yours.
- **Value in CKD Education** with Alexander Liang, MD – How to set up CKD Education in your practice.
- **Ancillary Service Implementation** – Amanda Walker, MBA, BSN, CMPE and Anika Porter – Hear from practice administrators how they have utilized and implemented CCM, TCM, Ultrasound, and Optimal Start programs.
- **Leadership in a Crisis** – Stacey Loomis, CMPE, Kelly Anderson, Terry Black and David McKay, MSM – Managing your practice during a pandemic.
- **Practice Governance** – Jason Greis and Scott Downing – Prevalent practice structure types and necessary governance documents – Jason and Scott are great – simplify the difficult.
- **Billing and Documentation** – Suzanne Leathers, CPC and Tiffany Jones – Billing do’s and don’ts; experience with OIG audits; and documentation/billing requirements for ancillary services.

This outstanding lineup of sessions, prepared especially for practice managers, contains over four and half hours of focused and relevant education.

I hope to “see” you at the RPA Annual meeting – March 18 – 20. Make the time to take the time to be the best you can be for your practice. ♦

Ms. Stevens is an administrator at Midwest Nephrology Consultants, P.A., in Kansas City, MO, and can be reached at [sstevens@mncpc.com](mailto:ssstevens@mncpc.com).

For Early Career Nephrologists: The History is Still Relevant

By Shaun Conlon, MD



Like many providers, I was happy to see the new changes to the evaluation and management documentation guidelines that began this year. It has been easier to document my clinic notes without having to worry about a bullet point system for the history and physical examination. However, I’m worried that some will interpret the new guidelines as a lack of importance of gathering a good history, particularly the social and family history.

The history of present illness section remains important. It tells the story of the patient’s illness, prior and current treatments, and the symptoms associated with that illness. Now that the new documentation guidelines are not prescriptive for this section, I hope that more providers will take the opportunity to tell the story of their patients. I always have a better understanding of my patients when I read other provider’s notes when written in a narrative.

The past medical history section is particularly important to a nephrologist. Given that many chronic illnesses, such as diabetes and hypertension, lead to kidney disease, the duration and course of these medical illnesses are important for us to understand how our patients developed kidney disease. Ideally, this section should be more than simply a list of diagnoses – it should contain details of those illnesses—their duration, their course, their complications.

Although many of us rely on others to gather a medication list (the medical assistants in our office, the nurses at the hospital and dialysis clinic), I have found it important to verify the medications ourselves so that list is accurate (think about the difference in pharmacology knowledge between a medical assistant or nurse and a physician). I have seen too many instances at the hospital where the admitting provider didn’t verify the medication list themselves only to make a medication error (e.g., omitting a home medication or giving a medication that had been discontinued). I find it useful to leverage the technology available to us in gathering this history, as often we can view the patients’ medication fill history through our electronic medical record.

The social and family history are important but unfortunately are often overlooked and insufficiently documented sections in our medical histories – I’ve learned over time that often these dictate much of the way that our patients view and treat their illnesses. I am sharing a few examples from my practice to illustrate this point.

Recently during dialysis rounds, I spoke with the interdisciplinary care team about a patient with severe uncontrolled hyperphosphatemia who frequently missed or rescheduled treatments. Her phosphorus was

so high that multiple binders were prescribed, including aluminum hydroxide. However, upon discussing her home situation in more detail, we discovered that she was trying to escape an abusive relationship with her husband. This was while she was trying to work as a remote middle school teacher and care for her college-age daughter. We endeavored to support her through these difficult social issues and subsequently, her dialysis compliance and phosphorus control have both improved.

I saw one of my transplant patients for a telemedicine follow-up recently. He had a kidney transplant almost two years ago, which has been functioning well. However, his quality of life since last spring has been poor because he has been isolated from his extended family. He lives in Atlanta to be close to his children and grandchildren, but since the start of the coronavirus pandemic, he had not been able to enjoy weekly gatherings with them as in the past. Despite a reaction to the first dose of the coronavirus vaccine, he was looking forward to the second dose so that he would be able to have gatherings once again with them.

I have been working with a young patient with advanced polycystic kidney disease for the last few years. I met her when she transferred care to me because she was having her second child at a hospital close to my practice. Despite the known risk to her renal function, she still chose to get pregnant for a second time. Her kidney disease has worsened since having her second child to the point where I have referred her for a kidney transplant evaluation. She’s only in her early 30s but has been realistic about the entire process since she watched her father cope with progressive kidney disease when he was at a young age.

These are just a few examples of stories my patients tell me about their lives because I am willing to listen. They trust me with these personal details, and I think for many of them these social and family issues have a higher priority than their medical problems. Knowing this information about our patients helps us to understand them better and allows us to partner with them in their care.

I know that all of you value the relationships that you have with your patients. I hope that the new documentation guidelines will give you the freedom to connect with your patients better and learn more about them. ♦

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.

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 RPA.



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RPA Fellowships Focus on Training Future Nephrology Advocates

During RPA’s Fall 2019 strategic planning session, the association agreed to increase its focus on developing the future of the specialty (fellows and early-career nephrologists). Therefore, in 2020, the RPA Board approved a new program which will award five 12-month public policy fellowships to early career nephrologists for those physicians in practice five years or less and five public policy fellowships to renal fellows. The first fellowships were awarded in January to a cohort of five exemplary nephrologists. (Fellowships will be awarded to renal fellows in July.) Participation in this program will provide these fellows with an increased understanding of the importance and impact of advocacy and how to shape kidney health policy. RPA is pleased to introduce the first class of early-career nephrologist fellows below.

As a young nephrologist, **Dr. Vishy Chaudhary** (Morgantown, WV) has been exposed to multiple aspects of nephrology practice, including clinical care, research, business management, ethics, and palliative care. “I did not see any opportunity for public policy and advocacy education at my stage of career. RPA’s unique public policy fellowship program is vital to shaping my understanding of our social systems and responsibilities, legislation and policymaking,” noted Dr. Chaudhary. “This fellowship is attractive because it prepares me to play a part in the planning and building for the future for our specialty. I also have the opportunity to be mentored by more seasoned nephrologists.”



the value of nephrology practice and optimize quality care for our patient population. In addition, RPA provides nephrologists with critical knowledge regarding regulatory issues necessary for practice management and appropriate billing and coding.”

“To be the best possible advocate for my patients in a cost-efficient manner, I must understand and navigate the intricacies of the health care system, apart from providing quality care. To tackle challenges, I must first understand them,” **Dr. Arjun Sekar** (Des Moines, Iowa) shared. “The AAKH initiative will change the landscape of health care delivery in nephrology. My interest in better understanding this federal initiative coupled with my aim of delivering equitable and top-quality care for my patients is what spurred my interest in the RPA’s public policy fellowship. A physician advocate is a patient advocate.”



Dr. Sherryl Mitchell (San Antonio, TX) is very passionate about helping patients find their voice and stand up for their rights. “One of the many reasons I was so interested to be part of the fellowship focused on public policy in nephrology is that I am confident that the RPA will give me the necessary information and tools on how to advocate for a better health care system and quality of life for our CKD, ESRD, and kidney transplant patients. For me, it is such an honor to have been selected as one of the fellows,” explained Dr. Mitchell.

“The public policy fellowship is a small step in the attempt to understand the structure and process for decision-making in the policy arena enabling me to advocate effectively for the benefit of our patients and nephrology practice,” explained **Dr. Raju Patil** (Ft. Worth, TX). “I have a deep interest in the machinery of advocacy. Understanding the perspectives from the various stakeholders is key. I commend the RPA’s lobbying efforts to increase



Dr. Ankur Shah’s (Providence, RI) interest in public policy stems from his experiences as a clinician-educator. “As a trainee, I often found myself frustrated by inequities in the health care system and began to seek out ways to influence the system to minimize these inequities. Amid my frustration, a mentor helped guide me towards policy and advocacy to modify systems that are not always directed in the right way. From here, it was a natural progression to the RPA, an organization widely recognized as a leader in policy and advocacy activities supporting nephrologists and individuals living with kidney disease. I am very much looking forward to learning from this fellowship and offering a new perspective as well,” Dr. Shah noted. ♦



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RPA Recognizes Excellence in Practice and Service

Congratulations to RPA's 2021 awardees! The following individuals have made significant contributions to the nephrology discipline throughout their careers and deserve our thanks and recognition for their achievements. Dr. Jeffrey Perlmutter will present the 2021 and 2020 awards to our recipients during the annual meeting.

2021 Distinguished Nephrology Service Award Goes to Dr. Chet Amedia



Dr. Amedia, an interventional nephrologist from Ohio, has served as chair of RPA's Healthcare Payment Committee (2001-2003) and as a member of the Board of Directors (2011-2017). He has contributed to numerous white papers and RPA policy documents and played an instrumental role in the development of RPA's publication on *ESRD in the Age of Managed Care: A Capitation Study*. For the past several years, Dr. Amedia has represented the nephrology specialty as a member of the

AMA CPT Coding Committee, where he has successfully obtained support for new CPT codes for nephrologists' procedures. Dr. Amedia has also served as a presenter at numerous RPA meetings and workshops, including leading RPA's coding and billing seminar series for several years.

Jennifer Huneycutt Receives 2021 RPA Distinguished Practice Administrator Award



Ms. Huneycutt has been a nephrology practice administrator for nearly 20 years and in this role at Metrolina Nephrology Associates, she has lead two mergers and the growth of providers from 20 to 70. As the Chief Operating Officer and Chief Financial Officer, she secured PPP funds in 2020, enabling all practice staff to remain employed during the pandemic. Under her leadership, Metrolina has been placed on the Top Places to Work in Healthcare by Modern Healthcare for the last two years. To help the

practice achieve its CKD population management goals, Ms. Huneycutt created a dashboard known as Kidney Compass. She has also helped many other nephrology practices meet their business goals in her role as CEO of Clear Edge Medical Management. Ms. Huneycutt has served as chair of RPA's practice managers' committee (2013-2016) and as a member of the RPA Board of Directors (2012-2018). She has spoken at numerous RPA meetings and continues to help design RPA's business benchmarking survey.

Mid-Atlantic Nephrology Associates, P.A., (MANA) Baltimore, Received 2020 RPA Exemplary Practice Award



Suzanne Przybyla and Dr. Paul Turer

MANA is a community-based physician-owned and governed nephrology practice whose mission is to provide comprehensive, consistent, high-quality care to patients with kidney and hypertensive diseases. Over the past three years, practice President and CEO Dr. Paul Turer has focused on creating collaborative relationships with payers, primary care physicians, and nurse case managers to increase early identification and staging of CKD, slow progression of CKD, improve timely nephrology referrals, and optimize

a patient-centric approach to manage the transition from CKD to ESRD treatment. Dr. Turer used the core principles outlined in RPA's



MANA Group Photo

Advanced CKD Patient Management Toolkit as the backbone for the practice's community outreach and care delivery approach. The practice also follows an internal quality improvement program reporting on measures that matter for CKD and ESRD patients. MANA began focusing on increasing home therapies by opening Kidney Home Centers more than a decade ago and opened a transitional care unit (TCU) in November 2018 to help transition patients who "crash" into dialysis in the hospital as well as those office patients who may benefit from its educational and support services.

RPA Presents Senator Bill Cassidy with 2021 Special Recognition Award



Based on over ten years of leadership in Congress on the effort to extend immunosuppressive drug coverage for the life of a kidney transplant, RPA is presenting its 2021 Special Recognition Award to Senator Bill Cassidy, MD (R-LA). Senator Cassidy is a member of the Senate Finance Health Subcommittee and was an original cosponsor of S.3353 - Comprehensive Immunosuppressive Drug Coverage for Kidney Transplant Patients Act of 2020, which was enacted at the

conclusion of the 116th Congress. Senator Cassidy was the driving force behind the enactment of the immuno bill in the Senate, and his staff played a key role in negotiating difficult implementation issues with CMS related to the bill. Previously, Senator Cassidy served three terms in the House representing Louisiana's 6th Congressional district and was a member of the Energy and Commerce Health Subcommittee in that chamber. Senator Cassidy is a gastroenterologist from Baton Rouge.

Dr. Franklin Maddux Received 2020 Distinguished Nephrology Service Award



As a nephrologist, information technology entrepreneur, and health care executive, Dr. Maddux has influenced how the specialty delivers kidney care. The first renal practice-based electronic health record software, now known as Acumen, had its beginning at Gamewood Data Systems, a company Dr. Maddux founded in 1991, which later became Health IT Services Group. When that company was acquired by Fresenius in 2009, Dr.

Maddux left his Danville, Virginia, practice, where he served as president from 1995-2005, to become Fresenius' Chief Medical Officer. Two years later, he became the dialysis company's Chief Medical Officer for North America, and in March 2019, he became the Global Chief Medical Officer at Fresenius. This career trajectory has enabled Dr. Maddux to interact with nephrologists from diverse settings to improve their ability to deliver value-based care. Dr. Maddux served as a member of the RPA Board (2006-2011) and as its Secretary-Treasurer (2009-2011).

Rep. Ron Kind (D-WI) Received RPA's 2020 Special Recognition Award



Congressman Kind has been a leader on legislation needed to extend immunosuppressive drug coverage for the life of a kidney transplant. During the past ten years that he has been working on this issue, he has either introduced or been the original co-sponsor on every immunosuppressive drug coverage bill, including the current version, H.R. 5534, the Comprehensive Immunosuppressive Drug Coverage for Kidney Transplant Patients Act of 2019. He is also a

co-sponsor of H.R. 1224, the Living Donor Protection Act of 2019. Congressman Kind has represented Wisconsin's Third Congressional District since 1997 and is a member of the House Ways and Means Health Subcommittee. ★◆



RPA Prepares for 117th Congress, Suspends Contributions to Non-Certifying Legislators

Since the last *RPA News* article updating membership on the activities of the RPA PAC, a lot has occurred in Washington, D.C. As a result of the attack on the U.S. Capitol on January 6, many companies and associations with political action committees have reconsidered their policies and practices regarding campaign donations to legislators who refused to certify the election. Accordingly, the RPA PAC Board met in January to deliberate on this issue, among others, and made the decision to suspend all contributions to the 147 members of Congress who did not vote to certify the presidential election results for the duration of the 117th Congress (or until January 2023); this decision will be revisited in advance of the 118th Congress.

This determination was not made lightly. PAC Board members considered the mission of the RPA PAC (*...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*) juxtaposed with the grave threat to our democracy and republic represented by the violence on January 6 and the subsequent vote that evening. Additionally, the Board reflected on whether this decision would compromise the ability to effectively advocate for nephrology practice and high-quality kidney patient care.

Given that in the past the RPA PAC has only made contributions to 7 of the non-certifying legislators, and that the PAC's contributions are primarily focused on the committees of jurisdiction for Medicare (Senate Finance, House Ways and Means, and House Energy and Commerce) that are not heavily populated by these lawmakers, it was determined that the ability of the PAC to be the voice of nephrology on Capitol Hill would not be adversely affected.

We recognize one potential ramification of the PAC Board's vote to suspend these contributions is that it might impact your decision to contribute to the RPA PAC this year. We understand that there are diverse points of view on this issue. The PAC Board was deliberative and thoughtful in making its decision.

With regard to the typical activities of the PAC, the usual post-election break and the desire to regroup after early January resulted in RPA PAC not participating in events during that period. However, this pause is about to conclude and events with legislators such as Senator Bill

Cassidy (R-LA, member of the Senate Finance Health Subcommittee, 2021 RPA Special Recognition Awardee, and champion of the just passed immunosuppressive drug bill) and Representatives Debbie Dingell (D-MI, member of the House Energy and Commerce Health Subcommittee and supported on vascular access issues) and Jaime Herrera Beutler (R-WA, long time advocate for organ donation and mother of a kidney transplant recipient) are being scheduled. The RPA PAC will also host a virtual reception later this spring in conjunction with RPA's Capitol Hill Day on May 21. Watch your email and the RPA website for details regarding this event.

With the acknowledgement that celebrations must be kept in perspective in these difficult times, nephrology experienced a great advocacy year in 2020. Inclusion of the immunosuppressive drug coverage provision in the year end stimulus package, coupled with

the positive outcome for physician reimbursement emanating from that bill, made for one of the most successful legislative policy cycles for the specialty in years. A crucial reason for that success is the work of the RPA PAC in highlighting issues of concern for nephrology during meetings with the legislators in a position to make a difference. Please help RPA PAC maintain its relationship with key Congressional leaders by donating to the RPA PAC today at <https://www.renaldm.org/page/PAC> or send a personal check to RPA PAC, 1700 Rockville Pike, Suite 320, Rockville,

MD 20852. If you have any questions please contact RPA's Director of Public Policy Rob Blaser or the RPA PAC Treasurer Mary Orgler at 301-468-3515, or at rblaser@renaldm.org or morgler@renaldm.org. As always, thank you for being a nephrology professional, and for being an RPA member. ☆◆

RPA PAC is a separate, segregated fund established by RPA. Voluntary contributions by individuals to RPA PAC will be used to support candidates for public office regardless of political affiliation who demonstrate their belief in the principles to which the profession of nephrology is dedicated. Contributions from corporations and associations as well as medical practices are prohibited by federal law and cannot be accepted. Contributions to the RPA PAC are not deductible as charitable contributions for federal income tax purposes.



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RPA is pleased to recognize and thank the following practices who support the association. All of the clinicians in these practices belong to the RPA and are committed to helping the association represent and serve nephrology professionals in their pursuit and delivery of quality kidney care. If you would like to learn more about the special benefits provided to single invoice practices, please contact Katrina Murray, membership concierge, at kmurray@renalmd.org or 301-468-3515.

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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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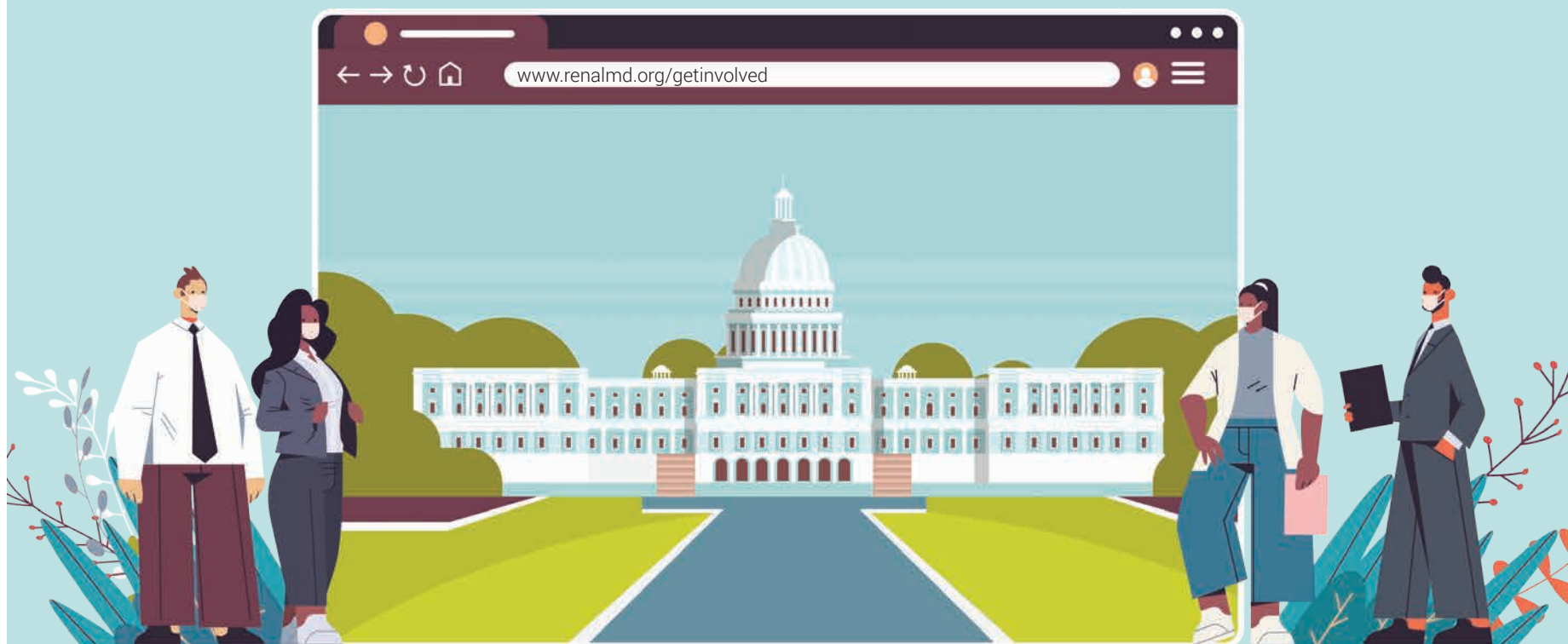


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**All kidney professionals and practice
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