RENAL PHYSICIANS ASSOCIATION
RPA Renal Physicians Association
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RPA News
The Advocate for Excellence in Nephrology Practice | Vol. XXXXII No. 2

# RPA Recognizes Excellence in Practice and Service

During the RPA Annual Meeting several awards will be presented in recognition of outstanding contributions and service to nephrology. Congratulations to our 2025 awardees!

## Exemplary Practice Award


### Kidney Specialists of Southern Nevada

*This award recognizes a nephrology practice that is uniquely incorporating and supporting RPA's suggested practices and strategic efforts while meeting the needs of its community.*

Since its founding in 1976, Kidney Specialists of Southern Nevada (KSOSN) has been a cornerstone of nephrology care in Southern Nevada. With over 60 providers and 100 support staff across eight locations, including two state-of-the-art vascular access centers, KSOSN continues to lead the region in comprehensive kidney care. Their integrated approach encompasses all aspects of nephrology, including patient education, dialysis center collaboration, and a specialized transplant team in partnership with the University Medical Center, which ranks #1 out of 256 transplant centers for the fastest patient transplants.

KSOSN has experienced impressive growth, with a 70% increase in size since 2019, including the introduction of roles like Care Navigators and RN Educators. Their commitment to innovation is evident through initiatives such as a comprehensive peritoneal dialysis program and the development of a stand-alone home dialysis unit, enhancing care for vulnerable populations.

Their continuous improvements in patient care, operational efficiency, and program development, particularly their CKCC program—have led to remarkable advancements. In 2024, KSOSN saw substantial increases in patient encounters, program expansion, and employee retention.

## Distinguished Nephrology Service Award

### Eileen D. Brewer

*This award recognizes an individual physician member who exemplifies RPA's mission and goals and has demonstrated local and/or national leadership to that end.*

Dr. Brewer is a dedicated advocate for improving care to pediatric patients with kidney disease. She is a past member of the RPA Board of Directors, whose dogged recognition and reminders of the important role played by pediatric nephrologists added greatly to board member edification such that the pediatric nephrology community was served in meaningful ways that continue to elevate expectations. Additionally, she served for many years in the realm of the AMA RUC to which she lent her time and expertise without hesitation, influencing many by her cogent and clear manner of explanation.

Dr. Brewer is known for her time and dedication to the next generation of nephrologists, always willing to discuss career planning, as well as her teaching and mentoring of all types of learners. She is frequently found updating and modifying talks for medical students, residents, fellows, nurses, dietitians, social workers, and patients both locally and nationally.

Dr. Brewer's dedication and contributions to both RPA and the nephrology community (pediatric and adult alike) have been steadfast, comprehensive and significant, surpassed only by her humility and exuberant energy. As her many awards attest, she continues to be highly regarded in the community and moreover, is a tribute to the profession and RPA.

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## Distinguished Practice Administrator Award

### Toni Ambrosy

*This award recognizes an individual RPA member who has an active role in managing or assisting with managing a nephrology practice and who exemplifies RPA's mission, goals and objectives.*

As the Practice Manager for North Houston Nephrology & Diagnostic Associates, Ms. Ambrosy is known for her commitment and leadership. She is generous with her time and expertise, always willing to answer questions, offer guidance and provide valuable insights, and serve as a mentor to her peers. Her expertise in accounting, advertising, building and JV management, among other areas, makes her an asset not only to her practice, but to the RPA.

Ms. Ambrosy has been a longstanding member of the RPA Practice Managers Committee and Policy, Advocacy, Leadership (PAL) Committee, as well as a contributor to the Renal Physicians Guide to Nephrology Practice.

## Outstanding Advocate of the Year Award

### John Ducker, MD

*The Outstanding Advocate of the Year award recognizes RPA members who have answered the call to participate in RPA's advocacy efforts.*

Dr. John Ducker of Nephrology Associates of Northern Illinois is a nephrology champion, consistently participating in RPA's Capitol Hill Day, regularly contributing to the RPA PAC, and serving as RPA's top "Power Advocate" in the Legislative Action Center. Dr. Ducker is also a past member of the Board of Directors and a member of the Policy Advocacy Leadership (PAL) Committee and frequent speaker at the Annual PAL Forum, among other roles he has held at RPA.

## Special Recognition Award

*This award recognizes individuals who have been active in supporting the mission, vision and strategic goals of the organization.*

### Tom Duvall

Mr. Duvall is the division director of the Division of Special Populations and Projects at the Center for Medicare & Medicaid Innovation, part of the Centers for Medicare & Medicaid Services. He has been one of the driving forces behind the implementation of kidney payment models, both before and after the introduction of the Advancing American Kidney Health Initiative. Mr. Duvall has regularly sought RPA's input on model revisions and has been open to implementing RPA recommendations when feasible.

### Representative Brett Guthrie (R-KY)

Congressman Guthrie has served as the U.S. representative for Kentucky's 2nd congressional district since 2009. He is currently the chair of the Energy and Commerce Committee in the U.S. House of Representatives, having previously chaired the committee's Health Care Subcommittee. Although Rep. Guthrie's leadership roles have limited his sponsorship of relevant legislation in recent Congresses, he has remained committed to RPA's legislative priorities over the years, particularly regarding Medicare physician payment and living organ donation.

RPA deeply appreciates the consistent contributions of Mr. Duvall and Rep. Guthrie to the advancement of kidney care in the U.S., and we proudly congratulate them as recipients of this award.

**For over 20 years, RPA has recognized and thanked members and friends of RPA and the kidney community for their outstanding accomplishments and contributions.**

**Nominations for RPA Recognition Awards are accepted each fall. Celebrate your colleagues by nominating them for a 2026 award!**

INSIDE THIS ISSUE...





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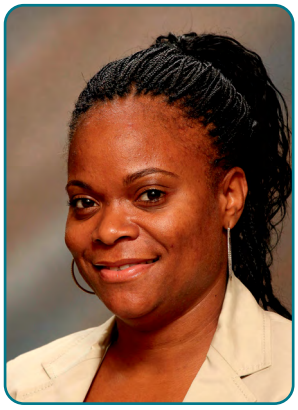
# A Fresh Season at RPA: Moving Forward with Momentum



Adonia Calhoun Groom, CAE, CMP
RPA Executive Director

And the time has come. It is officially Spring. RPA is busy on many fronts raising our voice and contributing to critical discussions in the policy and regulatory space. The buzz and excitement around the **RPA 2025 Annual Meeting** has registration booming. Las Vegas, Nevada is shaping up to be an ideal location to bring together kidney professionals from across the United States to reconnect with colleagues, share challenges facing nephrology and explore solutions.

Internally, the second year of the RPA strategic plan is unfolding, and efforts are underway to further evaluate and enhance how we engage with our members, stakeholders, and the larger kidney community. We are deep under the hood working to ensure you can not only get what you need from us in the most effective and efficient way but you also have increased opportunities to participate and experience new and timely initiatives. Our focus on pursuing inclusive expansion, innovating to thrive, and championing a sustainable profession remain intact. We will continue to seek new, diverse, and underrepresented voices to participate in all levels of the organization. We will continue to create space and opportunities to encourage those who want to engage to do so. We will continue to have critical discussions and investigate ways to promote innovation in the changing kidney landscape. In the coming months, look out for new policy webinars, education for renal fellows, and an education series intended to support business operation needs and trends of practice managers and administrators. During this time of change, transition and uncertainty at the Federal level, RPA is busy elevating our voice and contributing our expertise directly to lawmakers and regulators, participating in a number of kidney coalitions, and partnering with multiple organizations to ensure our concerns and your voice are heard. Whether we are advocating for equitable physician pay, prior authorization fixes, telehealth extensions, quality and equity in organ procurement and transplantation, or other legislation to optimize care, delivery and patient outcomes, we need you. Please visit the **RPA Legislative Action Center** and respond to our advocacy alerts as they arise.

We hope we'll see you in just a few days at the JW Marriott Las Vegas The Resort at Summerlin, as the RPA Education Committee has put together an incredible program filled with the innovative news, tools and resources to support you, the nephrology professional. With the goal of promoting more interactive learning formats, wellness and work-life balance, the 2025 Annual Meeting will usher in new opportunities to not only learn differently but walk away with tangible take aways that can be applied in practice right now. Back by popular demand, the **2025 RPA Medical Director Workshop 2.0** will feature an interactive, advanced program covering facility finances, managing conflict in the unit, your role in surveys, case-based discussion and more. Seats are still available and registration will be available on-site. Also new this year, RPA Committee Meetings have moved from the usual early morning Friday and Saturday meetings to Thursday afternoon (April 3) starting at 4:30 pm prior to the RPA Welcome Reception. RPA Committees are a great way to get involved in RPA, learn and grow with your peers, and contribute to the thought leadership and development of initiatives and RPA positions. I encourage you to join an **RPA Committee today**.

In response to workshop participant feedback, the **2025 RPA Nephrology Coding and Billing Workshop** will focus on frequently requested content. Some of these new or expanded areas include accounting for and how to document the typical complexity of medical decision making (MDM) present in nephrology care and appropriate reimbursement, documentation tips, changes for 2025 billing for the G2211 complexity adjuster and acute kidney injury services, and an expanded presentation on revenue cycle management. Back by popular demand are topics such as inpatient dialysis, telehealth, and the families of chronic care management services will remain. Meanwhile, outpatient dialysis, kidney disease education, and claims review and audits will move to the resource section. If you are unable to attend the Coding and Billing Workshop during the annual meeting, the on-demand version will be available in May. Additionally, RPA now offers custom RPA Coding and Billing Training Sessions for practice who participate in the Single Invoice Program (SIP). With success in multiple practices thus far, RPA now offers a customized, 2–3-hour virtual sessions for RPA member practices tailored to your specific needs. RPA staff will work to ensure the content covers your most pressing needs with time built in for critical questions and answers to ensure you walk away with what you need to be successful. Interested in your own workshop, inquire at **rpa@renalmd.org**.

Last, as nephrology professionals continue to deal with workforce challenges, burnout, heavy patient loads, prior authorization, reimbursement, and other practice uncertainties, RPA is here. Our members are exploring the most pressing and critical issues facing you, working to recommend solutions, and sharing resources and expertise to support each other along the way. If you have a colleague who is not a member and needs a little encouragement to join, please share the reasons you engage with RPA and why you find your membership valuable. Visit **www.renalmd.org** to renew or invite your colleagues to the RPA community today. I look forward to joining you for great education, networking and some fun in Las Vegas.

# This is No April Fool's: Toward a Promising Future

Keith Bellovich, DO
RPA President

Dear Colleagues,

As I write this message, policy changes continue to unfold more quickly than most of us can keep up, so please understand that there may be differences between my words here and what is actually happening at the time you read this message.

From my perspective, I remain filled with gratitude for the opportunity to serve you as President of the Renal Physicians Association. I assure you that what we have accomplished and what we plan to accomplish in the years ahead is no April Fools' jest. At the conclusion of what promises to be a fantastic annual meeting, my tenure as president concludes, but I assure you our incoming President, Gary Singer, assumes the role with a listening ear, fresh ideas, and continued energy to lead our association. It has been my honor to serve alongside each of you, as a community of extraordinary professionals dedicated to advancing renal medicine and improving patient care.

The renal field continues to evolve while navigating an ever-changing healthcare environment unlike any before. We now have the advantage of an experienced Executive Director in Adonia Calhoun Groom, a passionate and experienced staff, and a strong, continuous leadership structure that will serve us well in these uncertain times. Together, we have navigated pivotal challenges in the payment structure, quality measure development, billing and coding, and care delivery models while keeping our focus on what truly matters—our patients. Looking back over the past two years, I remain incredibly proud of what we have accomplished as an organization.

Thanks to the concerted efforts of all our volunteer members, we have worked toward improved patient outcomes and experimented with innovative care models. While we have made progress, you will undoubtedly discover during this upcoming meeting that there is still much work to be done. The continued incredible success of our organization requires ongoing dedication and a renewed commitment to sustained innovation.

Education and advocacy remain at the forefront of our mission, now more than ever, as we attempt to guide our various national leaders through uncertain times. We need your collective voices to resonate clearly for those who face difficult leadership decisions. Our advocacy efforts remain a trusted resource for those uncertain about the potential impact of their decisions and we will ensure that the voices of kidney care professionals are heard and valued. Our prior success in shaping kidney care legislation and reimbursement models reflects the historical impact of our collective power and determination. We cannot afford to stand idle—nor can our patients.

I encourage each of you to remain engaged and active members of our association and, more importantly, invite a friend along! Everyone's participation as an active member and contributor to our PAC is crucial to sustaining this momentum and achieving our strategic goals.

In parting, I extend sincere gratitude to our board members, committee chairs and members, and each and every member of our association for your support, dedication, and friendship. It has been my privilege to serve as your President, and look forward to continuing the mission as immediate Past President alongside you.

Together, we will continue to foster the necessary innovation, advocacy, and excellence in pursuit of optimal kidney care for ALL!

Thank you for entrusting me with this role and for your unwavering commitment to our shared mission. Let us look forward, united, to a future filled with promise and progress.

Make sure that at this meeting, "what happens in Vegas doesn't stay in Vegas", but becomes the springboard for continued innovation for our profession and for our patients for many years to come!

Thank you all for your trust in me.


***Keith and Debbie Bellovich at the RPA 50th Anniversary Gala.***

# RPA Welcomes New Board Members

RPA welcomes Virginia Irwin-Scott DO, Anika Porter, and Ted Shaikewitz, MD, to the RPA Board of Directors. They recently sat down with RPA News for an interview.

## Virginia Irwin-Scott, DO, MBA, CPE, FASN, FACOI

Dr. Irwin-Scott's career in medicine began as an ICU/CCU RN, where she worked alongside two nephrologists who would change the course of her professional life. "They were the ones called in when no one else knew the answer. They solved the issues," she recalls. Inspired by their expertise, she decided to go back to school, pursuing a bachelor's degree in biology and premed with the singular goal of becoming a nephrologist. Decades later, she had the opportunity to thank one of her mentors, Dr. Ellis, for being the spark that ignited her passion for the specialty.

Another pivotal influence in her career came from Dr. Joseph Pitone, who inspired her from her first day of medical school. She was his first nephrology fellow in the Kennedy Health System, now Jefferson NJ. Dr. Pitone encouraged her engagement with RPA, and after joining private practice in 2004, it became her lifeline—not just for managing patient care but for navigating the complexities of billing and business management. Dr. Irwin-Scott is a longtime member and current chair of the RPA Quality, Safety and Accountability (QSA) Committee.

Dr. Irwin-Scott's pursuit of knowledge led her to complete her CPE and later earn an MBA, which propelled her career forward. Nearly three years ago, she transitioned from clinical nephrology to a national role as the National Director of Kidney Care role at ChenMed, a large primary care organization. Now managing the care of 80,000 CKD patients, she has developed a strong understanding of population health and its implications for patient outcomes. Her role involves managing a dedicated team of 15 RNs who provide support for patients in late-stage CKD and ESRD, focusing on optimal starts and transitions of care.

When asked about her goals for her Board service, Dr. Irwin-Scott replied, "I hope to bring additional understanding of population health to the organization–How nephrology integrates with Primary Care to facilitate and support disease management, but also the recognition that we need to empower Primary Care to own the early disease management.  I also hope to continue to share my AI knowledge with the organization."

Dr. Irwin-Scott is a New Jersey native and has resided in Marlton for 30 years, where she raised four children with her husband. In her free time, she loves to travel and visit her children who are spread across the country. She also loves to ski, read, and is a passionate Peloton enthusiast —serving as a moderator for the Peloton Female Physicians Facebook page. In addition, she's a lifelong learner and will continue to evolve!

## Anika Porter

A Louisiana native, Mrs. Porter's journey in nephrology began with a call from a friend in need. What started as a temporary favor quickly evolved into a full-time commitment, one that would not only change the course of a practice but also spark a career rooted in financial optimization and business growth. "I wasn't there to make everyone happy. I was there to increase revenue—and that's exactly what I did." From the beginning, the managing partner of her former practice encouraged her to join RPA, believing it would be instrumental to her growth and development. "He was absolutely right! This organization has proven to be one of the best memberships I have ever been a part of, offering invaluable learning experiences and opportunities for professional growth," noted Mrs. Porter.

Mrs. Porter specializes in financial optimization, leveraging her expertise to unlock the true earning potential of businesses. But she's not just a numbers person—her expertise extends to healthcare consulting, where her insights enhance both operational efficiency and patient care. Her approach is holistic, combining the art of practice management with the science of operational excellence, ensuring that both healthcare providers and patients benefit from a more effective, streamlined experience.

As a board member, her goal is to strengthen the voice of practice managers, "We play a critical role in bridging the gap between clinical excellence and operational efficiency, and I believe that by working collaboratively with physicians, we can drive meaningful advancements in both patient care and the business of nephrology. I am deeply committed to this organization and passionate about strengthening the synergy between clinical leadership and practice management to create sustainable, high-quality care models that benefit patients, providers, and the industry as a whole," she explains.

Outside of practice management, Mrs. Porter is also a podcaster and Christian speaker. Through her platform, she shares powerful messages of faith, success, and personal growth. In her free time, she enjoys exploring new places, shopping, and diving into other creative endeavors.

## S. Theodore Shaikewitz, MD

Dr. Shaikewitz has spent his career advancing in the field of nephrology, driven by a passion for helping patients and improving medical practices. Born and raised in St. Louis, Missouri, he moved to California for college at Stanford, then returned to St. Louis for medical school at Washington University. His career path took him west again, where he completed a nephrology fellowship at the University

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# And Now for Something Completely Different

At the risk of cementing this column's place in the pantheon of boomer memory vehicles, fans of the 1970's British comedy show Monty Python will recall a brief between-sketch intro to the next segment provided by ensemble player John Cleese, in which he would loudly declare, "and now for something completely different." What followed was always a trademark absurdist skit, entirely unrelated to what came before. According to Wikipedia, examples of the skits included "Man with a Tape Recorder Up His Nose," "Self-Defence Against Fresh Fruit," and "Hell's Grannies," a takeoff on the Hell's Angels. American audiences did not always get the British sense of humor, but for those that did, well, IYKYK (that is, if you know you know).

Fast-forward to the politics of 2025 in the United States, where we are truly in for something completely different. President Trump's victory in the presidential race was part of the somewhat unexpected sweep of both chambers of Congress and the Executive Branch in the November elections. Both the presidential race and the battle for control of the House were razor close. The tight margin will have implications for governing, particularly for House Speaker Mike Johnson (R-LA), who has the narrowest House majority in modern U.S. history (according to the Pew Research Center). As a result, there will be acid test issues, like federal appropriations and extension of the debt ceiling, that are certain to test the limits of Mr. Johnson's—and President Trump's— influence and ability to corral the votes of outlier legislators.

Looking back at the end of 2024, while it may be cliché to use a phrase like "It was the best of times, it was the worst of times," in describing contrast between good and bad, but wow, December 17–18 certainly felt that way regarding Congress's consideration of the end-of-year Medicare package. Late on the evening of December 17, the continuing resolution (CR) containing the must-do Medicare extender provisions for 2025 was finalized, marking perhaps the most significant set of victories for organized medicine in nearly a decade. The conversion factor (CF) fix was set at 2.5%—still a cut, of course, but substantially better than the 1.4%-1.8% adjustments of recent years. Congress also extended the alternative payment model (APM) bonus at an increased rate of 3.53%, nearly double the percentage bonus for 2024. The existing telehealth flexibilities were extended for two years, and the geographic practice cost index (GPCI) floor of 1.0 was extended for one year. There was even progress on living organ donation, as the Honor Our Living Donors (HOLD) Act was included, an RPA-endorsed bill that allows more living donors to qualify for out-of-pocket expense reimbursement. All great news.

However, overnight and into the day on December 18, Trump "advisor" Elon Musk posted dozens of social media messages—some highly inaccurate—lambasting the CR as Congress conducting business as usual. By evening, Mr. Trump joined the chorus via Truth Social, and that version of the CR was effectively dead. Two days later, a much slimmer version of the CR was enacted, including a three-month extension of both the telehealth flexibilities and GPCI floor, and none of our other wins remained.

How this all played out could offer some insights of what may happen in the early days of the second Trump administration. First, although the defeat of the original version of the bill (which Mr. Musk clearly wanted) occurred, Mr. Trump had hoped to include a debt ceiling extension, which did not happen. In other words, Mr. Musk got what he wanted, and Mr. Trump did not. Secondly, in the early hours of December 20, when the Senate was voting on the CR, numerous provisions based on bills previously passed by the House were incorporated, without Republican opposition. Essentially, this means that some Republican Senators were defying Mr. Musk. While the early weeks of the new Trump administration indicate that Mr. Musk has an open runway to pursue his objectives, it will be interesting to see if this initial Congressional pushback resurfaces later in 2025.

Moving forward, government funding and many other issues will have to be addressed by March 31. Positively for medicine, President Trump has reportedly promised Rep. Greg Murphy, MD (R-NC, and new leader of the GOP Doctors' Caucus) a retroactive physician pay fix in March. Further, Rep. Buddy Carter (R-GA, and incoming Chair of the House Energy and Commerce Health Subcommittee) has already said that the historically positive CR package that was blocked on December 18 would be the template for an extenders package in March. [***Editor's note:*** We recognize that substantial change may have happened by the time you read this. As always, stay tuned to RPA information platforms for the latest developments].

Regarding congressional leadership and committee assignments, this is encouraging news for the kidney community. First, Speaker Mike Johnson (R-LA) was reelected, and while this is not necessarily kidney relevant, he has demonstrated a commitment to governing and providing some degree of stability (admittedly a low bar, but it could have been otherwise). On House committee assignments, Brett Guthrie (R-KY) will chair the full Energy and Commerce (E&C) Committee. He had a son who was born with a kidney abnormality, and as noted Rep. Carter will be the E&C Health Subcommittee Chair (he was one of the original co-sponsors of the ESRD Orals-Only Extension bill). Over at Ways and Means (W&M), Jason Smith (R-MO), full committee chair, and Vern Buchanan (R-FL), health subcommittee chair, have long histories with the kidney community, having served as lead sponsors of the KCP CKD bill in the past. Carol Miller (R-WV,

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*"And Now For Something Completely Different" continued from page 6*

and now Co-Chair of the Congressional Kidney Caucus) has positioned herself as the lead kidney legislator in the House and is also a member of the W&M health subcommittee. In the Senate, Mike Crapo (R-ID) is the Senate Finance Committee chair and was an original cosponsor of the KCP CKD bill in previous sessions. John Barrasso, MD (R-WY) is the chair of the Senate Finance Committee (SFC) Health Subcommittee and an orthopedic surgeon. Meanwhile, Bill Cassidy, MD, Chair of the Senate Health, Education, Labor, and Pensions (HELP) Committee is a liver disease physician.

As for what might happen later this year, much will depend on how FY2025 appropriations are resolved. A prevailing thought at press time is that a CR for the rest of the fiscal year will be used to fund the government, something that fiscal hawks oppose, but may be the only pathway to avoid a shutdown. However, the process is already significantly behind schedule, making a CR highly likely.

Speaking of a shutdown, while all the responsibility of governing on the Republicans now, congressional Democrats are facing their own difficult choice on that issue. Traditionally, Democrats are the party seeking to avoid a shutdown (given their belief in the government's potential to do good for its citizens), while Republicans tend to be much less concerned about shutdowns (given their inclination to believe government is an obstacle to progress). This year, however, based on their perception of the first month of the Trump II administration as overly extreme, and that congressional Republicans have allowed the Executive Branch to exert disproportionate influence over the legislative process, there is significant pressure for Democrats to provide zero assistance to Republican leadership efforts. The problem with that is (1) it goes against every instinct that Democrats have; and (2) they are leaving themselves vulnerable to blame if the government does shut down. This would be unprecedented—the GOP has historically lost the shutdown blame game—but we are in strange times.

On issues of consequence to nephrology, RPA's 2025 legislative agenda is discussed elsewhere in this edition of *RPA News,* but briefly it includes addressing short- and long-term physician payment shortfalls (passing H.R. 879, the Medicare Patient Access and Practice Stabilization Act, would be a huge step forward), extension of the alternative payment model bonus (with H.R. 786, the Preserving Patient Access to Accountable Care Act, as the relevant legislation), and improvements in living organ donation policies (no bills introduced at press time, but legislation is expected soon). If Rep. Carter's hope to use the December 2024 package as the template for the March Medicare package came true, all these issues may have already been addressed in part.

Other relevant issues likely to be pursued in this Congress include:

- Legislation promoting innovation in the ESRD Prospective Payment System (ESRD PPS) for dialysis facility reimbursement. This is the latest iteration of the CKD community bill, now scaled down to focus solely on innovation.
- A bill to delay inclusion of oral-only drugs in the ESRD bundle. This bill was not included in the December CR, but is still being pursued.
- The Medicare Secondary Payer (MSP) reform bill, which addresses the June 2022 Supreme Court decision allowing out-of-network or reduced coverage for ESRD beneficiaries.
- A staff-assisted home dialysis bill that is highly likely to be pursued by its previous proponents.
- Legislation addressing the misuse of prior authorization (PA) by insurers. This bill garnered widespread congressional co-sponsorship and organizational endorsements last year but was notably absent from the December package.

Two other Hill issues that RPA staff will be watching closely are potential developments regarding site neutrality provisions that could negatively impact vascular access services, and whether Congress moves to rein in Medicare Advantage plans. Regarding site neutrality, the theory is that if Medicare paid the same amount for certain services despite substantial current differentials, it would eliminate perverse incentives and save money. This approach, however, may be both ill-informed and rife with potential unintended consequences, but it remains a cost-saving measure and has the support of policy advisory groups, like the Medicare Payment Advisory Committee (MedPAC). As for potential constraints on Medicare Advantage plans, there is word that Republican legislators who previously advocated for market-driven policies free from government interference, now recognize that the Medicare Advantage plans have become overly powerful and that guardrails are necessary.

It is important to bear in mind that all the thoughts expressed above are grounded in a conventional Washington, D.C. policy development mindset, yet we are in an era that really is something completely different. That said, RPA will continue to, as they say in golf, "play it as it lies," and advance nephrology's interests as effectively and comprehensively as possible.

# RPA PAC: A Tool for Engagement

Cindy Corpier, MD

Last summer after accepting the opportunity to serve as the RPA PAC Board Chair, I was asked what my first priority would be. Once I learned that out of 3,500 RPA members, fewer than 5% donate to the PAC, the answer was obvious: increase engagement. In the lead up to the election, with nonstop political donation requests coming to me (and, I'm sure most of you) via emails and texts, I didn't think PAC donation requests would be met with much success. Yet, regardless of the election's outcome, the challenges confronting the nephrology community would continue to mount, making increased advocacy and engagement both urgent and necessary. My solution was to seek out opportunities to educate younger nephrologists and fellows on the theory that showing them the results of RPA's 50 years of persistent effort, they might be motivated to become involved for the good of their specialty and their patients.

The presentation titled "Where We Are & How We Got Here: Nephrology Regulatory History," juxtaposes major political developments affecting healthcare against the history of clinical developments in dialysis and renal transplantation starting with the Social Security Act, signed by President Franklin D. Roosevelt in 1935. A prominent source for this timeline is Dr. Christopher Blagg's superb article published in AJKD (March 2007), "The Early History of Dialysis for Chronic Renal Failure in the United States: A View from Seattle."

More recent developments covered in the presentation include the passage of the Affordable Care Act (ACA) and MACRA, tracing the evolution from ACOs to ESCOs to current value-based care models (CKCC, ETC), an overview of the Advancing American Kidney Health Initiative, and the launch of the Improving Organ Transplant Access (IOTA) model, set to commence in July 2025.

On the clinical side of the timeline, we highlight major breakthroughs, including the progress of immunosuppressive therapies, the introduction of erythropoietin, and the use of ACE inhibitors in diabetic kidney disease, through the recent game-changing advances of SGLT2 inhibitors, the MRA finerenone, and GLP-1 drugs.

The **RPA Timeline** dating from the organization's incorporation in 1974 to present, generously provided by RPA Staff, was useful to show a selection of key advocacy items affecting patient care as well as physician practice and reimbursement. This was followed by an overview of the House and Senate committees with jurisdiction over healthcare and RPA legislative priorities. Additionally, we discussed other national organizations engaged in nephrology advocacy, along with local and state medical organizations to consider, such as the Dallas County Medical Society and Texas Medical Association. We highlighted direct involvement provided by the RPA's annual Capitol Day and Texas's White Coat Days in Austin, during the biennial Texas Legislative Session on First Tuesdays.

In Dallas, where I practice, we have three nephrology fellowship programs: Baylor University Medical Center (BUMC), Methodist Dallas Medical Center (MDMC), and University of Texas Southwestern (UTSW). The BUMC and MDMC programs are led by are led by my colleagues at Dallas Nephrology Associates, who promptly agreed to let me speak at their fellows' conferences in November. In December, I was invited to present to the February UTSW Renal Grand Rounds.

By that time, the budget deal that included the important advocacy successes—partial relief from the 2.9% Medicare pay cut, a 3.53% alternate payment model bonus, and inclusion of the HOLD act providing financial relief to living donors—was thwarted, leaving only telehealth and geographic practice cost index (GPCI) victories through March 31. With a generous assist from Keith Bellovich and Rob Blaser, who shared updated slides on the current regulatory and legislative state of play, I was able to present a timely accounting to the UTSW group of fellows and faculty.

I also made sure to tell the fellows at the start of each presentation that while nothing we discussed that day would help them on their Nephrology Board Exam, the regulatory environment impacts every aspect of our work—from the treatments available to our patients to the reimbursement rates for our services.

My plan is to connect with the other renal fellowship programs in Texas and those in Louisiana (my home state) and offer to visit. I will also encourage my fellow PAC Board Members to engage the programs and practices in their regions.

As a reminder for our members who are practicing nephrologists and administrators, the RPA PAC is nonpartisan, RPA dues are not used for PAC activities, corporate donations are not allowed, only individual donations that are not tax-deductible are accepted. PAC donations are directed toward members of the House and Senate who serve on healthcare-related committees and support kidney care and nephrology. ***Importantly, these activities benefit 100% of the RPA membership.***

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*Dr. Corpier is a nephrologist with Dallas Nephrology Associates. Dr. Corpier earned her medical degree from Louisiana State University in Shreveport. She completed internal medicine residency and renal fellowship at Baylor College of Medicine. She also completed a research fellowship at Beth Israel Hospital.*

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The final two slides of this presentation offer a dose of pragmatism balanced by encouragement.

> *"You're either at the table, or you're on the menu."*
>
> *Do all the good you can,*
> *By all the means you can,*
> *In all the ways you can,*
> *In all the places you can,*
> *To all the people you can,*
> *As long as you can.*
>
> *"You may not care about politics, but politics still cares about you."*

Please contribute to RPA's efforts by donating to the RPA PAC today or sending a personal check to RPA PAC, 1700 Rockville Pike, Suite 320, Rockville, MD 20852. If you have any questions, feel free to contact RPA's Director of Public Policy, Rob Blaser, at 301-468-3515, ext. 118, or at **rblaser@renalmd.org**. You may contact the RPA PAC Treasurer, Mary Orgler, at **morgler@renalmd.org**.

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.

*"RPA Welcomes New Board Members" continued from page 5*

of Colorado and a transplant fellowship at the Oregon Health Science Center. It was in Oregon where he met his now wife, Dr. Nora Franceschini, who was completing a renal research fellowship.

Dr. Shaikewitz's interest in nephrology began during high school when he spent a summer in New York City with his uncle, Dr. Norman Deane, a nephrologist who played a key role in the early days of dialysis in the city and was also a past president of RPA (1982–83). He was struck by how much focus was dedicated to the kidneys and fascinated by their complexity. This early exposure set the stage for his future in medicine, and as he progressed through medical school and residency, he found that nephrology offered a holistic integration of medical knowledge, which deeply appealed to him.

After spending a few years in Las Vegas, Drs. Shaikewitz and Franceschini moved to Durham, North Carolina, where she trained clinically at Duke and later earned a Master of Public Health at the University of North Carolina. Meanwhile, Dr. Shaikewitz joined Durham Nephrology Associates, where he remains to this day. He is also the longtime chair of the nephrology division, as well as Chairman of Pharmacy and Therapeutics and the Medication Safety Committee at Duke Regional Hospital. More recently he became a member of the Hospital's Medical Executive Committee and has been involved in developing an effective electronic medical record system from the nephrology perspective.

A few years after joining Durham Nephrology Associates, Dr. Robert Gutman, his senior partner and a former RPA board member, tossed a notice about an upcoming RPA Capitol Hill Day on the table at an office meeting. This sparked Dr. Shaikewitz's interest, and he began attending RPA Capitol Hill Day and the Policy Advocacy Leadership (PAL) Forum annually. Eventually, he joined the PAL Committee and served as Chair. Along the way, he has met many of the dedicated professionals who make RPA an exciting and effective organization.

Dr. Shaikewitz sees joining the RPA Board as an opportunity to gain deeper insight into nephrology's latest developments, benefiting both himself and his patients. He expects Board membership to keep him closer to the cutting edge of our changing world and allow him to bring timely information back to Durham, noting, "To the Board I can contribute my experience as a general nephrologist, and my work on medication safety and the electronic medical records process."

In his free time, Dr. Shaikewitz enjoys exploring new concepts through literature and art. He also enjoys hiking and hopes to find time to hike into the mountains where the mountain goats are while in Las Vegas for the RPA Annual Meeting.

# Reflections from An Outgoing Board Member

*RPA leadership and staff recognize the contributions of the outgoing board members who have volunteered numerous hours of service to advance RPA and nephrology forward. We are grateful for the time they have taken from their professional and personal lives to support their professional society.*

*Drs. Sallie Israelit and Ms. Charlotte Dixon will be recognized for their contributions on during the RPA Annual Meeting. Ms. Dixon recently reflected on her experience serving on the Board of Directors.*

**Charlotte Dixon, MBA**, became involved in RPA when she was hired into her first nephrology practice in 2017. At the time, one of her physicians, Rubina Kahn, was adamant that she join RPA, insisting that it would be the best step she could take to gain a strong footing in her new position. Ms. Dixon reflected that she was not wrong about the value of RPA, stating "The work you do is important, and being a part of an organization like RPA is vital to making sure you are able to continue practicing."

Ms. Dixon joined the Board of Directors during the COVID pandemic when she had recently moved from Texas to Hawaii. When asked about what she's enjoyed about being on the RPA Board of Directors, Ms. Dixon noted that, aside from the long flights from Hawaii, she has found the experience immensely rewarding. She described the people she has met and the relationships she has built through board service as deeply inspiring. Additionally, Ms. Dixon has greatly valued the opportunities to bring her voice and the voice of those she represents to important discussions. In particular, she has appreciated the opportunity to help shape RPA's new vision and mission during the strategic planning process.

Ms. Dixon is very proud to be a part of the Practice Managers Committee that has developed many of the well-received sessions featured in the business management track of the RPA Annual Meeting over the last three years. She noted the engagement and involvement of so many on that side of nephrology care is instrumental to the success of the specialty moving forward, and that she will continue to remain actively involved in RPA Committees. When asked what else she would like to share, Ms. Dixon reflected, "RPA is the best aggregate voice that nephrology has and supporting RPA, and importantly, participating—is more vital than ever."

# RPA 2025 Legislative Agenda Highlights Physician Pay, Living Organ Donation

RPA's process for developing an annual legislative agenda is straightforward. First, RPA staff compile a slate of possible issues for consideration in the coming year. Next, the Government Affairs Committee (GAC) deliberates on these issues. Finally, once the GAC finalizes its recommendations, they are forwarded to the RPA Board of Directors for discussion and approval during the January Board meeting. Then, of course, the real work begins. This article will review how RPA's 2024 legislative agenda fared and outline the Association's 2025 priorities.

Briefly, RPA's 2024 priorities were on the cusp of significant victories in December until a long-negotiated Medicare package developed as part of the 2025 appropriations process was scuttled; details on this can be found *From Capitol Hill* column (on page 6).

For 2025, the RPA GAC and Board determined that there is no reason to remove Medicare physician payment, the APM bonus extension, or living organ donation from our legislative agenda, especially since success in these areas may be close at hand in both the short and long term (hopefully to be determined in March 2025 after this issue goes to press).

The GOP Doctors Caucus continues to be influential in the House and they are being joined by a growing number of Democratic physicians in the chamber—all of which is promising for Medicare Part B payment reform. Key Republican leaders have reportedly received a pledge from President Trump to address physician reimbursement before March 31, and there continues to be strong emphasis on developing a more sustainable system based on the Medicare Economic Index (MEI) which would account for inflation. Thus, advocacy efforts should in this area should continue.

Additionally, the surprisingly large APM bonus in the December Medicare package suggests a commitment to promoting value-based care on which organized medicine should capitalize. As RPA is the socioeconomic representative for nephrology in all policy spheres, we must lead on these issues by ensuring they remain central to our legislative agenda.

Regarding living organ donation (LOD), in addition to the clear benefits of the issue and RPA's increasing emphasis on transplant policy, this is also an area of substantial Congressional interest. The fact that the Honor Our Living Donors (HOLD) Act—which would reduce financial barriers for living organ donors—made it into the end-of-year (EOY) package was an encouraging surprise for LOD advocates. This level of commitment from Congress signals a strong opportunity for progress, making it essential to retain LOD on RPA's legislative agenda.

The Chronic Kidney Disease Improvement in Research and Treatment Act—developed by Kidney Care Partners (KCP) for every Congress in recent memory—is expected to be significantly scaled back this session. Rather than its usual omnibus approach, the bill will likely focus solely on innovation aspects of the ESRD Prospective Payment System (PPS), as it remains the only Medicare payment system without an innovation payment pathway.

This shift presents both opportunities and challenges for RPA. While we have always advocated for an innovation adjuster in the PPS, this narrower approach eliminates provisions related to expanding kidney disease education (KDE), promoting the nephrology workforce through loan forgiveness, and restoring Medicare Advantage Network adequacy provisions for dialysis care. Given those changes, the RPA has decided not to include the bill on the 2025 legislative agenda but will continue to advocate for innovation in the ESRD/PPS dialysis facility payment.

Other relevant legislation that seems likely for introduction in the first session of the 119th Congress would pertain to the prior authorization (PA) bill left over from last session, efforts to constrain Medicare Advantage plans otherwise, and the bill to address ESRD Medicare Secondary Payer (MSP) patient protections which would seemingly be adversely affected by the June 2022 Supreme Court decision on the issue. RPA staff's perspective is that the PA and Medicare Advantage bills are likely to gain traction this year, and the ESRD MSP bill less so.

Finally, RPA will again build in some flexibility in priority setting for the first half of 2025 at least. The introduction of the Kidney Patients Act last year (this is the bill that would have extended the exclusion of oral-only drugs from the ESRD bundle) is only the latest example of bills that came up during the Congressional session that RPA ultimately endorsed. This will allow the association to remain nimble to respond to evolving events.

In summary, the 2025 RPA legislative agenda will consist of the issues below, with others to follow if appropriate:

- **Medicare Part B payment reform, addressing both the 2025 conversion factor cut and long-term system restructuring.**
- **Extension of the alternate payment model bonuses.**
- **Multiple legislative initiatives aimed at promoting living organ donation.**

If you are an RPA member interested in helping determine RPA legislative agenda in future years, please join the Government Affairs Committee (GAC). To ensure your voice is heard, participate in committee calls and discussions. The GAC will hold an open committee meeting in Las Vegas on April 3 at 5:30 p.m. You can also **submit a committee interest form to join**.

Finally, be sure to **save the date for RPA's Capitol Hill Day on October 10**, where you will be able to advocate for RPA's legislative agenda with your members of Congress.

# Trends in Physician Employment

## *Where does nephrology and the RPA fit?*

Hanna Webb, MD, MPH

I think by now we have all read the articles, so I won't belabor the point, but the truth is inevitable: more than half of physicians are now employees. We put ourselves through medical training at great physical, emotional, and financial cost, hoping to practice medicine in a way that makes us feel like we are doing some small amount of good in the world. Of course, the appeal of acquiring a high value skillset that is respected by many, along with the financial and job stability that come with that, is nothing to ignore. Practically speaking, once we leave training, many of the jobs we find that fit the bill require an employment contract with a large healthcare system, and just like that we become *employees.* What this means for our lofty ambitions and altruistic ideas, I think, is complicated.

In case you need convincing, the 2022 American Medical Association (AMA) Benchmark Survey reported that the percentage of physicians working in private practice groups dropped to 46.7% (less than half!), with the rest of us working directly for a hospital or hospital-owned practice. In Indiana, where I live, over 75% of physicians are employed by hospitals. Additionally, between 2012 and 2022, there was a national decline in the number of physicians working in groups of 10 or fewer, representing a shift toward larger group practices, even for those avoiding hospital-based contracts. The same report showed a significant drop in physicians who were owners of their practice, from 61% in the early 2000s to 44% in 2022, a trend driven mostly by young physicians (Figure 1). While there is shockingly little data within the field of nephrology to corroborate these trends, I think most of us would agree the larger shift is happening to us as well.

So, assuming nothing drastic has changed since 2022 (I don't think it has), early career nephrologists—like me—are increasingly taking jobs with large health systems—which I did. Everyone has their own reasons for making these choices, but the most frequently cited benefits include greater financial stability and potentially less administrative burden. For any graduating fellow, it is certainly tempting to take a job with a well-known local health system that will manage your clinic, set up your referral base, and place you in an arrangement with numerous other specialists and hospital beds at your disposal. In return, all the hospital system asks in return is that some of the revenue generated by physician services helps fund administrators and leadership for their role in the organization. This makes sense, since I don't think I have ever talked to a doctor about their motivations for going to medical school and heard them say they were interested in negotiating payments with insurance companies, learning the minute details of a value-based care contract and ensuring compliance, all while staffing an outpatient clinic all.

Large healthcare systems benefit by keeping patients within their hospital and referral base, of course, squeezing funds and patients from independent physician groups and servicers. While the driving factor for this is obviously financial, I will play devil's advocate and acknowledge that there may be a patient benefit in creating a mini version of universal healthcare, where patient records are easily accessible and communication between specialties is seamless. If only, I would add, we could find a way to achieve this without the drawbacks—for both independent physicians and employed physicians alike.

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

**Figure 1:** Exhibit 8. Percentage of physicians who are owners: differences by age and over time[1,2]

| | 2012 | 2022 | 2012–2022 CHANGE |
|---|---|---|---|
| Under age 45 | 44.3% | 31.7% [a] | -12.6 pct. points |
| Age 45 to 54 | 53.9% | 43.6% [a] | -10.3 pct. points |
| Age 55+ | 59.6% | 51.3% [a] | -8.3 pct. points |
| All physicians | 53.2% | 44.0% [a] | -9.2 pct. points |

| AGE 45 TO 54 IN 2012 | AGE 55 TO 64 IN 2022 | 2012–2022 CHANGE |
|---|---|---|
| 53.9% | 49.7% [c] | -4.2 pct. points |

Source: Author's analysis of AMA 2012 and 2022 Physician Practice Benchmark Surveys.
Notes: [1] The bottom panel tracks the cohort of physicians born between 1958 and 1967. In 2012 that cohort was between the ages of 45 and 54 and, in 2022, between the ages of 55 and 64. This comparison tracks the change in employment status of that cohort over their career. [2] Significance tests are for differences between years. 'a' is p<0.01, 'b' is p<0.05, and 'c' is p<0.10.

# Balancing Medicine and Parenthood: The Challenges of Returning to Work

Elizabeth Kurtz, MD

It has been an incredible journey this past year as a new parent. These precious moments have passed by faster than I could have ever dreamed. But as I look back, there is much I wish I could tell my former self. I have focused on some of these themes in my recent series of columns. In my last article on balancing medicine and parenthood, I will highlight some of the struggles new parents face when returning to work.

The landscape of working parenthood has changed over the past few decades. We are far less likely to find ourselves in traditional gender roles of working fathers and stay-at-home mothers. Young families today are more likely to be dual-income parents with shared childcare responsibilities. Once we return to work, we return as different people—with new priorities and a new set of complicated logistics. Finding a balance between career responsibilities and being an engaged parent requires careful planning. Here are some considerations:

**Childcare Arrangements:**

- What type of childcare best suits healthcare professionals?
- For healthcare workers, in particular, the demands of call weeks and night shifts often do not align with traditional childcare options like daycare or nanny services. How can we navigate irregular schedules when conventional childcare services are unavailable during nights or weekends?

**Variables:**

- Which factors—such as available support, financial constraints, and career logistics—affect our childcare decisions?
- Which partner has the flexibility to handle emergencies?
- How much are we willing to sacrifice in terms of pay and career advancement?

**Logistics:**

- How do we ensure quality time with our children despite demanding schedules?
- How do we manage childcare emergencies?
- Should we have designated time off to care for a sick child, and if that is not possible, how do we balance patient care while also being the emergency caregiver?

Every family rises to these challenges differently. Early on, I realized that I could not do this alone. In my dream of becoming a parent, my partner and I took a leap of faith and moved back to Pittsburgh to be close to our support network: family, friends, and church community. Yet, despite the wealth of support, we have found it challenging to get this right.

The cost of childcare has risen by approximately 26% over the last decade, with the pandemic further exacerbating the crisis. Securing childcare is not just expensive—it is daunting. We signed up for daycare when we found out we were expecting, and we remain on waitlists to this day. We have interviewed countless nannies and been let down by others. We scramble and adapt: the nanny is sick, our child is too ill for daycare, or an emergency requires a hospital visit. Childcare disruptions often throw our schedules into disarray—particularly in medicine, where taking time off is not as simple as it is in other fields.

To navigate this lack of flexibility, we plan meticulously, with multiple backup strategies—Plan A, B, and C—while relying on the sacrifices of those around us. Instead of taking traditional vacations, we reserve days off every few weeks as emergency childcare, a strategy that has proven invaluable. We also make a conscious effort to be fully present with our children in the hours after work and before bed. To manage our workload, we have learned to maximize small moments—fitting in work and personal tasks during commutes and unconventional hours. We shift tasks like preparing charts and completing notes to late evenings or early mornings, and we postpone conferences and travel unless absolutely necessary.

Yet no matter how much we plan, work and life inevitably collide. This raises an important question: How can medical practices best support working parents? Supporting working parents is not just a moral imperative—it's a practical necessity for retaining talent in nephrology. The field already faces a shortage of specialists, and the next generation of nephrologists will expect workplaces that prioritize work-life balance. Balancing career expectations and parenthood can be overwhelming, often leading some to transition to part-time work or leave the field altogether. To support retention, employers should consider implementing formal return-to-work programs for new parents. Additionally, facilitating discussions on flexible work schedules and shared responsibilities among new parents and early-career nephrologists can lead to more accommodating arrangements. There are also innovative solutions that can simultaneously drive our practices forward—such as integrating telehealth or enabling population health activities from home. By adopting these approaches, nephrology practices can cultivate a more supportive and sustainable work environment for the future, particularly for working parents.

Another reality of motherhood is breastfeeding, a deeply personal journey that comes with its own set of challenges. Every woman's experience is unique and faces a steep learning

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

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curve. Although it may be an uncomfortable topic for some, it is vital for administrators and colleagues to acknowledge and actively support nursing mothers during this transition. Legally, the Providing Urgent Maternal Protections for Nursing Mothers Act (PUMP Act) mandates that employers provide reasonable break time and a private (non-bathroom) space for lactating employees to pump milk during the workday. This right extends for up to one year following childbirth. In medicine, pumping presents unique challenges. We often multitask across various hospitals, clinics, and offices, making it difficult to find a dedicated lactation space. We constantly transport pumping supplies between locations and must ensure that expressed milk stays cold during transitions. Additionally, because our success is measured by the number of patients we see, pumping can feel like an impediment to productivity. Adjusting to this routine takes weeks, demands ongoing adaptation, and can even result in financial repercussions for nursing mothers.

When I discussed breastfeeding accommodations with my administrators, I encountered confusion. Many of my predecessors worked in an era when formula feeding was the norm. Today, the pressure to breastfeed is immense, amplified by social media and societal expectations. When I first returned to work, I hesitated to schedule pumping breaks, not wanting to inconvenience anyone. But as I struggled through those first few weeks, I realized that my determination to simply "rise to the challenge" was unrealistic. Nursing is not a binary on/off process—it involves managing a fluctuating milk supply to meet a baby's ever-changing needs. Some days, hands-free pumping is enough; other days, dedicated time is necessary. When I finally tried to incorporate pumping breaks later, it was much harder for staff to accommodate me, ultimately impacting both my well-being, my child's nutrition, and patient care.

To navigate this, nursing clinicians must continue to set clear boundaries. We must be honest about our experiences and extend ourselves grace, understanding that the return to work may not always go as smoothly as we had envisioned. With an increasing number of women in our field (both physicians and APPs), administrators should be proactive about scheduling dedicated pumping time for nursing mothers. This helps remove the stigma around pumping at work and supports a smoother transition back to the workforce while allowing mothers to fulfill the essential role of feeding their children.

As I have progressed in my medical career and journey as a parent, I have come to realize that we have the power to redefine expectations for the next generation. Most early-career nephrologists, regardless of gender, prioritize work-life balance and seek mentorship that models successful integration of career and parenthood. By fostering these conversations and advocating for parent-friendly policies, we can cultivate a workplace culture that genuinely supports working parents. Our collective efforts will not only enhance the well-being of our colleagues but also ensure that nephrology continues to thrive.

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

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So, the potential benefits of this employment shift exist for both physicians and the healthcare systems. However, as alluded to above, there are drawbacks— most of which have received far more publicity than any of the benefits already listed. The most widely recognized consequence of the physician employment shift is a truly tragic explosion in physician burnout and moral injury (Press, 2023). This is thought to be due to a general loss of autonomy for practicing physicians. Clinical medicine is highly nuanced and evolves rapidly, and issues that seem obvious to those working in the trenches are often overlooked by non-clinical decision-makers. Independent and physician-owned groups are more agile in responding to industry changes, while large healthcare systems often find themselves bogged down by administrative hurdles—or worse, unaware they are in the wrong space entirely. This disconnect between clinicians and managers, or administrators, can quickly create moral injury in physicians who feel pulled between doing the best thing for the patient and me meeting contractually required performance metrics.

Again, I will begrudgingly acknowledge the counterargument: perhaps physicians have not done a good job of educating themselves on the "business side of medicine," making it difficult to collaborate with administrators and further widening the divide. Finally, I must mention the paradox of increased administrative tasks for employed physicians, with most of us spending more time fulfilling insurance, billing, and documentation requirements than talking to our patients each day, despite our employment agreement.

I want to finish this probably-too-lengthy discussion with an acknowledgement that even though physician employment continues to grow in prevalence, private practice nephrology should not be discounted, as these practices continue to play an important role in nephrology care nationally. I asked to write these essays because there seems to be a lag in acknowledging the employed nephrologist in some spaces, and I worry it is a lost opportunity for advocacy and education for a large and growing part of the nephrology workforce. And, since this is part one of a three-part series, there's more to come—next, we'll explore physician advocacy and RPA's role in shaping the future.

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

Press, E. (2023, June 15). *The Moral Crisis of America's Doctors*. Retrieved from The New York Times Magazine: https://www.nytimes.com/2023/06/15/magazine/doctors-moral-crises.html

# Healthcare PE Investment: As Federal Headwinds Subside, a Gale Warning is Up in Many States

Jason Greis, Partner, Benesch

Private equity (PE) investment in the U.S. healthcare sector faces a complex and evolving regulatory and legislative landscape. Both federal and state authorities are intensifying scrutiny of PE investment, driven by concerns about market consolidation, quality of care, corporate profiteering and lack of financial transparency. As "headwinds" mount, particularly at the state level, PE firms and the healthcare businesses in which they invest, must be prepared to adapt their consolidation strategies.

## Federal Regulation and Legislation Related to Healthcare PE Will Likely Decrease

At the federal level, agencies such as the Federal Trade Commission (FTC) and the Department of Justice (DOJ) have heightened their oversight of PE activities in healthcare in recent years. In March 2024, the FTC conducted a workshop examining private equity's influence in the sector, expressing concerns over investment strategies that could undermine competition and affect care quality. Subsequently, in May 2024, the FTC and DOJ initiated a joint public inquiry to identify PE transactions potentially detrimental to quality care and that could dampen competition. The agencies sought public comment on the impact of various acquisitions involving private investment on patient safety, cost and quality of care. Former FTC Chair Lina Khan, whose term concluded in September 2024, cautioned against lax oversight of PE firms, particularly highlighting risks associated with practices like "strip and flip" and roll-ups that could lead to increased costs and diminished care quality. These efforts signaled a robust federal intent (at least under the former Biden administration) to monitor and regulate PE investment in healthcare.

The 2024 federal legislative session also saw the introduction of two pieces of legislation aimed at curbing healthcare PE—The Health Over Wealth Act introduced by Senator Ed Markey (D-Mass.) and The Corporate Crimes Against Health Care Act introduced by Senator Elizabeth Warren (D-Mass.). This legislation would require PE sponsors to provide enhanced public reporting and obtain licenses to make healthcare investments. PE sponsors and healthcare executives could potentially be subject to criminal and civil penalties if their actions are found to result in patient harm. Little substantive action has been taken to date on these bills and they currently remain mired in committee.

The political landscape, however, also influences federal regulatory approaches. While the Biden administration adopted an assertive stance toward regulating PE investment in healthcare, many commentators believe that President Trump's administration will likely take actions to spur PE investment and prioritize deregulation. President Trump has made repeated comments about decreasing the corporate tax rate that could benefit PE firms, and his administration has already taken significant steps to prioritize deregulation. For example, on January 31, 2025, President Trump signed an executive order requiring that whenever an agency promulgates a new rule, regulation, or guidance, it must identify at least ten existing rules, regulations, or guidance to be repealed.

## State Regulatory and Legislative Challenges to Show Signs of Rapid Intensification of Healthcare PE Scrutiny

State governments are also actively addressing PE investments in healthcare, with legislative measures aimed at enhancing transparency and protecting public interests. In February 2025, for example, California introduced Senate Bill 351 (SB 351) targeting the involvement of PE groups and hedge funds in managing physician and dental practices. This bill seeks to reinforce the state's existing prohibitions on the corporate practice of medicine and dentistry and prevent corporate entities from exerting undue influence over clinical decision-making. SB 351 is a revival of aspects from Assembly Bill 3129, which was vetoed by Governor Gavin Newsom in September 2024. The reintroduction of this legislation underscores ongoing concerns about the impact of PE on healthcare delivery in the State.

On January 8, 2025, Massachusetts Governor Maura Healey signed House Bill 5159 (HB 5159) into law, expanding regulation over PE investments in the state's healthcare sector. This legislation imposes stringent financial reporting requirements on PE investors, real estate investment trusts (REITs), and management services organizations (MSOs) involved in healthcare. The law aims to enhance transparency and enable regulators to monitor the financial practices of entities influencing healthcare delivery, ensuring that patient care remains the primary focus. Many other states including California, Connecticut, Illinois, Massachusetts, Minnesota, Nevada, New York, Oregon and Washington have also passed, or are considering enacting, laws requiring parties to disclose transactions involving private equity investment before closing a deal. Many of these state antitrust-style laws are based on model legislation from the National Academy for State Health Policy, which was created as a tool for states to increase oversight of healthcare transactions that could result in provider consolidation and increased cost of care.

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*Healthcare PE Investment" continued from page 15*

Finally, although the FTC attempt to ban employment non-compete agreements failed in 2024, states are continuing to actively regulate and scrutinize the use of non-compete covenants. Currently, four states ban the use of non-competes entirely and thirty-three states, plus Washington, D.C., have legislation restricting their use. As it becomes more difficult to bind providers to noncompete covenants following closing of a PE transaction, especially where providers are critical to healthcare infrastructure in a particular community, PE firms could become concerned that they may not receive "the benefit of their financial bargain" if the owners of a seller healthcare business can immediately compete with a buyer following closing a deal.

## Implications for Private Equity Investors

The intensifying regulatory environment presents a variety of challenges for healthcare PE investors:

1. **Increased Compliance Costs:** Enhanced reporting and transparency requirements necessitate robust compliance frameworks, leading to higher operational costs.
2. **Strategic Reassessment:** Investors may need to reevaluate acquisition strategies, particularly concerning roll-up practices and management agreements, to align with new regulations.
3. **Increased Time to Close:** State pre-transaction notification laws may increase the amount of time needed to close PE deals in some states and could result in enhanced scrutiny of deals where there are concerns that a transaction could decrease availability or quality of care or increase costs.
4. **Scrutiny Over Noncompetes May Change How PE Firms Protect their Investment:** In states preventing or significantly restricting employment noncompetes, PE investors could lose an important tool for ensuring they receive the benefit of their financial bargain after a deal closes. PE firms will either need to turn to alternative contractual protections to safeguard their investment in target companies, or alternatively the purchase price in some deals will need to account for this risk.
5. **Uncertainty in Federal Oversight:** The transition to a new federal administration and an unpredictable President introduces uncertainty regarding future regulatory approaches, requiring investors to stay adaptable and informed.
6. **State-by-State Variability:** Divergent state regulations compel investors to navigate a patchwork of laws, complicating multi-state investment strategies.

In conclusion, healthcare private equity investors must adeptly navigate a dynamic regulatory and legislative landscape. Proactive engagement with evolving policies at both federal and state levels is essential to mitigate risks and capitalize on opportunities within the healthcare sector.

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

## RPA Welcomes Leadership Development Program Fellows

**Romin Bonakdar, MD**
Chapel Hill, NC

**Aman Deep, MD**
Medford, OR

**Chintav Shah, MD**
Waipahu, HI

**Kinjel Shastri, DO**,
Pontiac, MI

# 2025 Telephone Services, APs and the MCP, and CPT Code 90970

**Question:** Our Medicare payer just rejected our claims for telephone services using codes 99441-99443, but I don't understand, we've been using those codes since they were put in place for the pandemic without a problem. Do those codes no longer work?

**Answer:** Correct, those codes no longer work. In fact, they have been entirely removed from the Medicare Fee Schedule as of January 1, 2025. They were theoretically replaced by a series of 17 codes developed by the CPT Editorial Panel for 2025, which include:

- Synchronous audio-video: 98000-98007
- Synchronous audio-only: 98008-98015
- Brief synchronous communication technology service: 98016, a single five- to 10-minute medical discussion not related to a previous E&M service within the last seven days or leading to one in the next 24 hours. This service replaces the CMS "virtual check-in" visit, which previously used the CMS Healthcare Common Procedure Coding System (HCPCS) code G2012.

However, CMS has assigned an inactive status ("I") to these services, so the appropriate codes (98008-98016) cannot be used to bill audio-only services, at least for now. As such, it is our understanding that the only way an audio-only service to a Medicare beneficiary could be billed is if video technology is unavailable to the patient, or the patient did not give their consent for the interaction to be conducted via audio-video technology but did consent for audio-only. If the interaction is audio-only, providers will need to list modifier -93 to indicate audio only service. [The specific defining language is *Modifier -93—use only for synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system]*.

RPA will monitor the status of the new CPT codes for services provided via audio-video or audio-only means and will keep membership apprised of any changes in this area.

**Question:** I need to know if a physician completes his monthly comprehensive visits, but does not complete a comprehensive note on one or several patients because they missed an appointment or were in the hospital, can our APPs (PAs or Nurse Practitioner) do the comp note and we bill under the APP? Right now, we bill per day if the patient does not have a comp note. Please advise on what is the best and correct way to bill. I have a physician who needs concrete confirmation on this. Thank you in advance for your assistance.

**Answer:** Yes, your APs (i.e., advanced practitioners) can perform the comprehensive visits (RPA uses the term 'complete assessments') and bill for those patients' monthly services under their PINs. They will be paid at 85% of the allowed physician rate (per the 85% rule). The Medicare Claims Manual confirms this interpretation, stating: *"If the nonphysician practitioner is the practitioner who performs the complete assessment and establishes the plan of care, then the MCP service should be billed under the PIN of the clinical nurse specialist, nurse practitioner, or physician assistant."* (Chapter 8, page 68).

**Question:** My practice wants clarification on CPT code 90970 for dialysis billing when patients are not seen for the full month. How does it work? When should we use it?

**Answer:** RPA has addressed the use of CPT code 90970 previously in Coding Corner but not in recent years so review of the issue is appropriate. First, CMS outlines the following situations, again in the Medicare Claims Manual, where the code should be used:

- Home dialysis patients (less than full month);
- Transient patients – Patients traveling away from home (less than full month);
- Partial month where there was one or more face-to-face visits without a complete assessment of the patient and the patient was either hospitalized before a complete assessment was furnished, dialysis stopped due to death, or the patient had a transplant;
- Patients who have a permanent change in their MCP physician during the month.

Additionally, the issues of (1) whether to bill for total days responsible for ESRD related care and not just dialysis days; and (2) whether the patient has to be seen by physician for at least one of the dialysis treatments to be able to bill 90970 for the total number days patient is under their care, have been previously addressed. On the first question, yes, the practice should bill for all of the days that the patient is under their care, whether seen on dialysis or not. For example, if the patient travels from another state, is under the care of the nephrology practice where he/she is visiting for seven days, and is seen once by the nephrologist, the practice should bill seven counts of CPT code 90970.

As to whether the patient must be seen by the nephrologist to bill for CPT code 90970, it is our understanding that a physical presence 'see the patient' requirement for 90970 is not set forth anywhere in federal regulation or in the Medicare claims manual, and this makes sense in that the daily code only pays 1/30th of the MCP, and CMS is not likely going to establish a physical presence requirement for a service where a single frequency count for the service pays a minimal amount (the national median non-facility limiting charge for 90970 is $10.25 for 2025). Also, recall that the home dialysis service did not have a see the patient requirement until the last few years, quite possibly indicative of CMS' recognition that such a requirement is not appropriate or necessary for limited use of the code. That said, RPA strongly recommends that if the frequency is approaching 7 days (i.e., a week's worth of time) the nephrologist should definitely see the patient in that time, not only to provide high quality patient care but also to support billing for the services for that amount of time. In short, a requirement to see the patient is

*continued on page 18*

*Healthcare PE Investment" continued from page 17*

not in our understanding spelled out anywhere, but if you're approaching a week's worth of medico-legal oversight of/responsibility for the daily dialysis patient, it is a good idea to see the patient.

**Question:** My doctors want to know: can we be reimbursed for training other physicians in our Ambulatory Surgery Center (ASC)?

**Answer:** RPA's interpretation is that this is not a covered service. To our knowledge, nothing in the Medicare Fee Schedule allows for one physician to train another in this capacity. When Medicare does cover training, it is for patient education (and, as of last year, caregiver training in uncommon situations), not for physician training.

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

## RPA RECOGNIZES CORPORATE PATRONS

The RPA Corporate Patrons Program is designed to augment the alliance between stakeholder industries and the RPA since corporate members of the nephrology community play an important role in optimizing patient outcomes. Gifts from corporate patrons are for scientific or educational purposes. During the year, RPA leaders meet with representatives from corporate patrons participating companies to discuss areas of mutual concern and interest. This informal dialogue benefits industry and the association. Potential donors should contact the RPA office to obtain additional information. Links to all of our corporate patrons' sites may be found at www.renalmd.org.

RPA is pleased to acknowledge the support provided by all of our corporate patrons in this issue of RPA News.

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### Exhibitor Showcases featured in the Exhibit Hall

- Boehringer Ingelheim/Lilly USA – Friday, April 4 at 8:30am
- Novartis – Friday, April 4 at 10:40am
- CorMedix Inc. – Saturday, April 5 at 8:30am
- Kyowa Kirin – Saturday, April 5 at 10:40am

### Satellite Symposium

*This symposium is an independent program within the RPA Annual Meeting. It is NOT part of the official RPA Annual Meeting as planned by the RPA Education Committee. RPA does not endorse any company, program or service provided by our partners. This program is provided for informational purposes and does not necessarily reflect the viewpoints of the RPA.*

### Changing the Course of Uncontrolled Gout Starts with You

Hosted by Amgen | Friday, April 4, 2025 | 7:30am – 8:30am

During this symposium participants will:

- Recognize that uncontrolled gout is chronic, systemic, and highly comorbid with a range of diseases1-4
- Learn more about KRYSTEXXA, an effective treatment option with a proven safety profile and over 14 years of real-world experience5
- Best practices for getting patients started with KRYSTEXXA

### Innovating in Dialysis: High-Volume Hemodiafiltration Can Benefit U.S. Patients

Hosted by Fresenius Medical Care
Friday, April 4, 2025 | 12:00pm – 1:30pm

The symposium will give a brief introduction on hemodiafiltration and describe the effect on the Quality of Life and mortality of patients. Speakers will discuss the impact of high-volume hemodiafiltration on sustainability.

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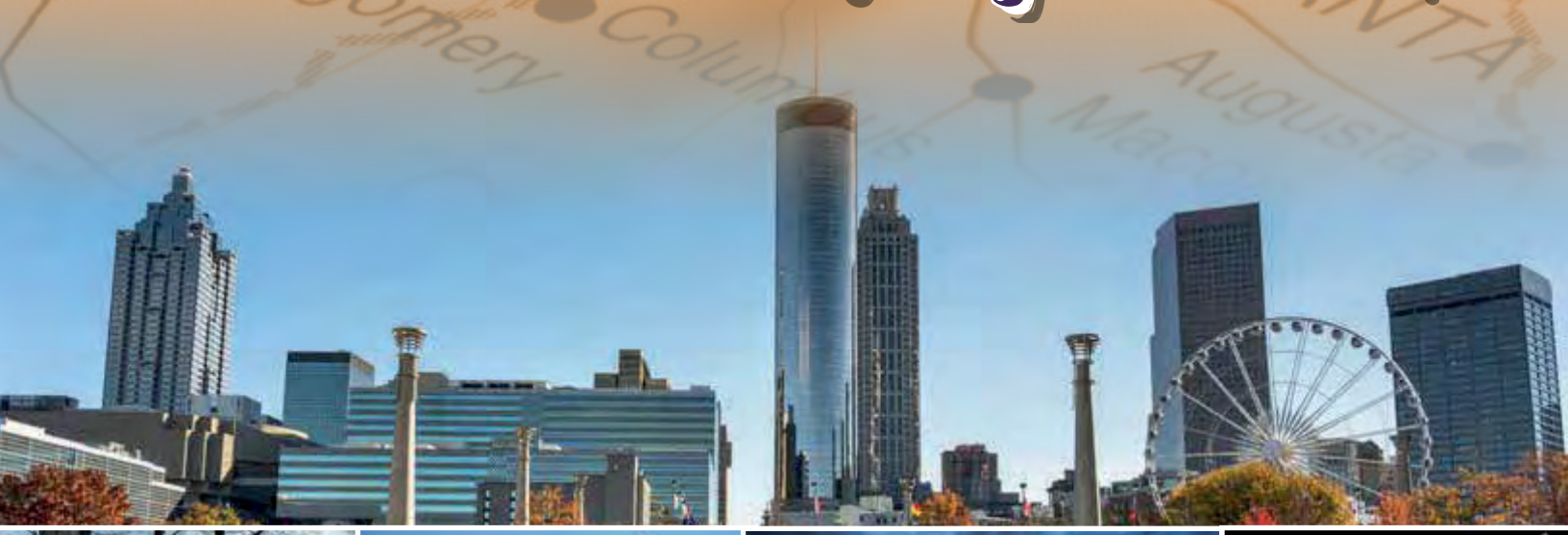
# MARK YOUR CALENDARS!

Join us **APRIL 16-19, 2026**, for another exciting RPA Annual Meeting experience in the ATL (Atlanta, GA). Don't miss out on networking opportunities, informative sessions, and Atlanta's famous delicious *peach cobbler*.

## We can't wait to see you there!





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