KIDNEY CARE PARTNERS

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KCP Comment on Section 232 Pharmaceutical Investigation
Docket No. 250414-0065; ID BIS-2025-0022

I. Introduction

Kidney Care Partners ("KCP") is grateful for the opportunity to submit a comment in response to the Notice of Request for Public Comments on Section 232 National Security Investigation of Imports of Pharmaceuticals and Pharmaceutical Ingredients (the "Notice") by the Bureau of Industry and Security ("BIS") within the Department of Commerce ("Commerce"), published on April 16, 2025. This comment addresses the reasons why the imposition of tariffs or other trade measures related to pharmaceuticals that are critical in the treatment of End Stage Renal Disease ("ESRD") are not necessary for U.S. national security and would have severe adverse impacts, including threatening the lives and health of ESRD patients. Trade remedies, such as tariffs, would restrict access to life-saving pharmaceuticals for a medication-dependent patient population and would significantly undermine the efficacy of Medicare programs designed to benefit this unique population. In addition, KCP notes that ESRD patients often have complex conditions and require access to other medications, and trade remedies that restrict access to these pharmaceuticals could be detrimental to the lives of ESRD patients and those outside of the ESRD population. Accordingly, we request that any tariffs or other trade measures imposed pursuant to this investigation exclude the ESRD pharmaceuticals identified in Appendix A.

II. Kidney Care Partners

KCP is a non-profit, non-partisan coalition of more than thirty organizations comprising patients, physicians, nurses, dialysis professionals, researchers, therapeutic innovators, transplant coordinators, and manufacturers dedicated to working together to improve the quality of care for individuals living with kidney disease.

III. End Stage Renal Disease and the Patient Population

ESRD is the last stage of chronic kidney disease ("CKD") and is characterized by permanent, irreversible kidney failure. Patients with ESRD include those who are treated with dialysis—a

process that removes wastes and fluid from the body—and those who have a functioning kidney transplant. According to the U.S. Renal Data System (USRDS), in 2024, approximately 831,000 Americans are living with ESRD.[1]

Due to the limited number of kidneys available for transplantation and the variation in patients' suitability for transplantation, about seventy percent of patients with ESRD undergo maintenance dialysis. Dialysis replaces the filtering function of the kidneys when they fail. Although improvements launched by President Trump's first Administration in 2019[2] are underway to promote in-home treatment options and transplantation, most patients on dialysis travel to a treatment facility to undergo hemodialysis three times per week for approximately four hours per treatment. Hemodialysis uses an artificial membrane encased in a dialyzer to filter the patient's blood. Patients receive additional items and services, including multiple life-sustaining ESRD Pharmaceuticals and biologics to treat co-occurring conditions such as anemia and bone disease that result from the loss of kidney function.

The ESRD population is unique among those that rely on pharmaceuticals. In 1972, Congress expanded Medicare to cover individuals diagnosed with ESRD regardless of age. This marked the first time that Congress allowed individuals to enroll in Medicare based on a specific medical condition rather than on age. Congress extended Medicare coverage to individuals with ESRD due to the lethality of the disease, the then-prohibitive cost of paying for dialysis, and the "indirect [economic] costs" that the disease inflicts on the nation.[3] To this day, ESRD remains one of only two diseases that makes an individual eligible for Medicare regardless of age or disability. In extending coverage to this population, Congress acknowledged that special measures were necessary to ensure ESRD patients would receive the life-saving dialysis treatment necessary to stay alive.

IV. Scope: ESRD Pharmaceuticals

KCP has prepared a list of pharmaceuticals, attached as Appendix A, that are critical to long-term treatment of ESRD, including dialysis treatment and treatment following a kidney transplant.

[1] Nat'l Inst. of Diabetes and Digestive and Kidney Diseases, ESRD Quarterly Update (May 2024), https://www.niddk.nih.gov/about-niddk/strategic-plans-reports/usrds/esrd-quarterly-update (select Prevalent Count Line Charts tab).

[2] On July 10, 2019, President Trump issued an Executive Order on Advancing American Kidney Health. *See* Trump White House, *Executive Order on Advancing American Kidney Health* (July 10, 2019), https://trumpwhitehouse.archives.gov/presidential-actions/executive-order-advancing-american-kidney-health/. This landmark policy commitment incentivizing kidney patient choice and quality improvement, modernizing Medicare systems to promote in-home treatments and transplantation, and implementing new delivery models designed to accelerate value-based care is a major milestone for kidney patients, their families and the community of providers, nephrologists, nurses, social workers and drug and device manufacturers that support them. **The Advancing American Kidney Health Executive Order (2019) remains today the most profound investment by any President in patients with this devastating disease.**

[3] S. Rep. No. 92-1230, at 1243–44 (1972) (statement of Sen. Hartke).

Section 1 of Appendix A includes pharmaceuticals that have been identified by the Centers for Medicare and Medicaid Services ("CMS") as required for dialysis treatment and are therefore covered by Medicare's Prospective Payment System ("PPS") for ESRD treatment.[4] Section 2 of Appendix A reflects the pharmaceuticals that are necessary following a kidney transplant, many of which are identified in Chapter 15 of the Medicare Prescription Drug Benefit Policy Manual, section 50.5.1, and Medicare Part Coverage.[5] Without the medications in Appendix A ("ESRD Medications" or "ESRD Pharmaceuticals"), ESRD patients would be unable to manage their condition.

For the following reasons, KCP respectfully requests that BIS carefully consider the life-saving ESRD Pharmaceuticals included in Appendix A and recommend excluding ESRD Pharmaceuticals from any future trade action, including tariffs.

KCP would also like to note that there are many Americans living with ESRD who have comorbidities that require access to other non-ESRD medications. As such, KCP respectfully requests that BIS consider the ramifications that tariffs on non-ESRD pharmaceuticals will have on those living with ESRD and the broader American patient populace.

V. Exclusion of ESRD Pharmaceuticals is necessary to save lives.

If ESRD patients lose access, even temporarily, to ESRD Medications, many will face severe health consequences, including death. ESRD dialysis patients require a variety of pharmaceuticals that are administered during dialysis to filter the patient's blood and prevent the buildup of toxins and fluids that is fatal. Many ESRD Medications are also necessary to provide dialysis and prevent severe, adverse complications related to ESRD, including anemia,[6] mineral and bone disorders,[7] such as hyperphosphatemia,[8] and secondary hyperparathyroidism,[9] among others. ESRD kidney

[4] Ctrs. for Medicare & Medicaid Sers., CY 2025 ESRD PPS Consolidated Billing List, Attach. B (Jan. 1, 2025), https://www.cms.gov/files/document/items-and-services-subject-esrd-pps-consolidated-billing-effective-1-1-2025.pdf.

[5] Medicare Program; Implementing Certain Provisions of the Consolidated Appropriations Act, 2021 and Other Revisions to Medicare Enrollment and Eligibility Rules, 87 Fed. Reg. 66,454 (Nov. 3, 2022).

[6] Anemia is a reduction in hemoglobin that occurs when the body does not have enough red blood cells or when the body's red blood cells do not function properly, affecting oxygen delivered to the body. Ninety-one percent of U.S. dialysis patients have been diagnosed with anemia and are prescribed medications to increase erythropoietin and hemoglobin levels.

[7] In patients with ESRD, mineral and bone disorder occurs when there is an imbalance in the blood levels of calcium and phosphorus. This mineral imbalance affects bones, heart, and blood vessels.

[8] Hyperphosphatemia is a condition characterized by elevated levels of phosphate in the blood. In patients with ESRD, the kidneys lose the ability to excrete phosphate effectively, leading to its accumulation in the blood. Phosphate lowering therapies are used in nearly 80 percent of dialysis patients.

[9] In ESRD, the kidneys' inability to filter waste products leads to decreased levels of calcium and elevated levels of phosphate. This triggers the parathyroid glands to produce excessive PTH, which further disrupts calcium and phosphate levels, causing secondary hyperparathyroidism.

transplant patients require daily immunosuppression medications to prevent rejection of the transplanted kidney. During their transplant course, kidney transplant recipients also require additional medications, such as pharmaceuticals needed for induction therapy and infection prevention. ESRD Pharmaceuticals protect the transplant patient and the donated kidney from rejection and related complications.

Most ESRD Medications are administered multiple times per week and missing any doses or treatments—whether the result of unaffordability or supply chain disruption—can have grave consequences for patients. The United States should not impose trade measures that would significantly limit or effectively wall off access to international pharmaceutical production. The importance of this access is paramount to the American ESRD patient population and therefore overcomes any perceived or potential national security concerns.

VI. Exclusion of ESRD Pharmaceuticals would be an appropriate form of relief for this vulnerable population.

Granting an exclusion to ESRD Medications from a broader pharmaceutical trade measure would be appropriate and would not hollow out the effect of said trade action. More than 831,000 Americans (or 0.24 percent) live with ESRD. In other words, ESRD patients comprise less than one quarter of one percent of the total U.S. population.[10] As a very small subset of the population, a carve-out specially designed for the vulnerable and medication-dependent ESRD population will not negatively impact national security or U.S. policy goals. Additionally, an ESRD exclusion would not undermine the overall efficacy of a trade action, including a pharmaceutical tariff, that is imposed on the pharmaceutical industry more broadly.

VII. The importation of ESRD Pharmaceuticals does not present a national security risk, and therefore, no special trade measures are required to protect national security.

A. Foreign supply chains are required to meet U.S. demand for ESRD Pharmaceuticals, but many countries that produce such medications are U.S. allies.

Approximately thirty percent of all pharmaceuticals are manufactured in the United States with many medications produced exclusively in other countries. KCP recognizes the importance of increasing domestic production, including within the pharmaceutical industry, but the capacity needed to support U.S. demand is not practical in the short or medium-term. With limited current domestic capacity, it would take significant time and investment to onshore domestic manufacturing, particularly in an industry that is subject to strict regulatory scrutiny. ESRD

[10] Nat'l Inst. of Diabetes and Digestive and Kidney Diseases, ESRD Quarterly Update (May 2024), https://www.niddk.nih.gov/about-niddk/strategic-plans-reports/usrds/esrd-quarterly-update (select Prevalent Count Line Charts tab); U.S. Census Bureau, U.S. and World Population Clock, https://www.census.gov/popclock/ (last visited May 7, 2025).

patients rely on life-saving medications on a daily basis and cannot wait for treatment until domestic manufacturing is more readily available.

Furthermore, although foreign supply chains are necessary to meet domestic need for ESRD Pharmaceuticals, any national security risks are effectively mitigated where these medications are produced in countries with which the U.S. has favorable relations. For example, a recent analysis found that seventy-three percent of all imported pharmaceuticals are produced in Europe, namely Ireland, Germany, and Switzerland.[11] In addition, many generic pharmaceuticals, including ESRD Medications, are manufactured in India. The U.S. has favorable political and trade relations with both Europe and India, and ongoing negotiations the Administration is conducting would make them stronger. It is therefore unlikely that these nations would restrict ESRD Medications as a foreign policy aim; however, the consequences of tariffs would pose significant risk to domestic supply and U.S. patients.

B. U.S. imports of ESRD Pharmaceuticals come from a diverse group of suppliers from various countries, limiting any potential national security threat.

For most ESRD Pharmaceuticals, there is a diverse pool of suppliers that produce these medications in several different countries, including in the United States. Many ESRD Medications can currently be procured from a variety of countries, such as Switzerland, India, France, Spain, and Germany. In KCP's assessment, no single country could restrict exports of these medications to gain leverage over U.S. foreign policy or national security. Global supply chain diversification protects U.S. access to life-saving medications.

Moreover, protecting this diversity of suppliers, rather than erecting barriers such as tariffs, ensures that supply chains critical to ESRD treatment remain available at all times. Tariffs and other trade actions often foreclose supply chains by making procurement prohibitively expensive, which would in turn limit the available options of ESRD Medications in the U.S. Faced with a limited list of suppliers and tariffs on many U.S. trading partners, the U.S. market would be unable to pivot to a different foreign supplier in response to supply chain disruptions or price increases in a particular market.

Furthermore, by limiting accessible markets through trade restrictions, manufacturers, providers, and patients would become more dependent on a smaller number of suppliers, creating greater risk that the U.S. would not have access to alternative suppliers when needed. Additionally, because ESRD Medications are a relatively small market with limited domestic supply, trade restrictions could dramatically reduce competition, creating incentives for domestic suppliers to raise prices while reducing incentives to increase production. It is imperative to protect the flexibility of both foreign and domestic ESRD supply chains.

[11] Maggie Fick, *Exclusive: US pharma tariffs would raise US drug costs by $51 billion annually, report finds*, Reuters (Apr. 25, 2025 12:34 PM EDT), https://www.reuters.com/business/healthcare-pharmaceuticals/us-pharma-tariffs-would-raise-us-drug-costs-by-51-bln-annually-report-finds-2025-04-25/.

C. Foreign governments do not subsidize/ have predatory trade practices in the ESRD industry.

Unlike in industries such as lumber, aluminum, and carbon, the International Trade Administration ("ITA") has not investigated or identified any dumping practices related to ESRD Pharmaceuticals. To the best of our knowledge, there are no antidumping/countervailing duty ("AD/CVD") cases related to ESRD Pharmaceuticals, which implicitly acknowledges that Commerce, ITA, and domestic producers have not identified state-sponsored overproduction concerns. Further, these government organizations have not investigated such pharmaceuticals for these state-sponsored concerns, indicating that the American ESRD pharmaceutical industry has not raised these concerns with Commerce and ITA.[12]

VIII. Tariffs or other trade measures would significantly disrupt the Medicare programs set up for ESRD patients by Congress and disrupt access to ESRD Medications.

ESRD patients are one of two unique patient populations eligible for Medicare regardless of age due to the severe and costly nature of the treatments required. The ESRD population accounts for approximately 1% of the Medicare population yet spending on all of their Part A and B care accounts for 7% of Medicare spending.[13] Accordingly, both ESRD patients and Medicare would be uniquely impacted by trade measures imposed on the pharmaceutical industry.

In 2008, Congress modernized how Medicare pays for dialysis care by creating a broad payment bundle called the "ESRD PPS."[14] Under the ESRD PPS, facilities receive a single adjusted payment that includes services, drugs, laboratory tests, medical equipment, and supplies. Medicare payments to dialysis facilities are then adjusted each year based on the ESRD market basket input price index which tracks the price increases for goods and services that facilities purchase to provide patient care.[15]

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[12] International Trade Administration, AD/CVD Search, https://access.trade.gov/ADCVD_Search.aspx (last visited May 7, 2025).

[13] Paulette C. Morgan, *Medicare Advantage (MA) Coverage of End Stage Renal Disease (ESRD) and Network Requirement Changes* (2021), https://www.congress.gov/crs-product/R46655; *see also* Nat'l Inst. of Diabetes and Digestive and Kidney Diseases, 2022 Annual Data Report, End Stage Renal Disease: Chapter 9, Healthcare Expenditures for Persons with ESRD, https://usrds-adr.niddk.nih.gov/2022/end-stage-renal-disease/9-healthcare-expenditures-for-persons-with-esrd.

[14] Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 110-275, 122 Stat. 2494, https://www.congress.gov/110/statute/STATUTE-122/STATUTE-122-Pg2494.pdf.

[15] The government's base payment rate for each dialysis treatment is intended to cover all operating and capital costs that efficient providers would incur in furnishing dialysis treatments. In 2025, the base payment rate is approximately $291 per treatment. *See generally* Medicare Payment Advisory Commission, Report to Congress at 168 (March 2025), https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC.pdf.

At the time Congress and CMS were developing the ESRD PPS, the Government Accountability Office (GAO)[16] and others who supported the new policy had emphasized that, when CMS implements such payment changes, it is important for the bundled payment rate to accurately reflect the *expected* costs of beneficiaries' care to ensure that efficiencies are not realized at the expense of beneficiaries' access to and quality of care. However, the potential introduction of *unexpected* pharmaceutical tariffs into a payment system that forecasts reimbursement based on the lagged prices of goods and services could immediately and irreparably harm the ability of dialysis providers to provide care to vulnerable beneficiaries and could have longer term consequences for Medicare outlays.

In the short term, dialysis providers would be required to absorb the price increases resulting from the imposition of tariffs, other trade measures, or onshoring pharmaceutical production. Although dialysis providers always seek to avoid any disruption to patient access, purchasing ESRD Pharmaceuticals at a loss is not financially sustainable, which could result in major provider shortages and reductions in treatment capacity for the entire treated population. The impact of these outcomes would cascade across Medicare as individuals with ESRD who cannot receive routine dialysis experience avoidable complications that result in greater utilization of physician and hospital care.

In the long term, the Medicare program would likely feel the effects of rising costs of ESRD Pharmaceuticals in its market basket updates, which would further strain the U.S. Treasury accounts used to fund Medicare. Higher costs caused by tariffs could result in private insurers forcing ESRD patients onto Medicare, which would result in significant cost increases to the U.S. government.

IX. If the BIS is inclined to recommend trade measures, KCP urges BIS to consider domestic incentives as an alternative to tariffs.

In the event BIS determines that trade measures on pharmaceuticals, including ESRD Pharmaceuticals, are necessary to protect U.S. national security, KCP respectfully submits that the U.S. government should consider alternatives that would not risk disrupting the supply of life-saving medications to ESRD patients, as would the imposition of tariffs. These alternatives could include:

- Implementing subsidy or grant programs to incentivize domestic production of APIs and completed pharmaceuticals;
- Implementing tax incentives for companies that manufacture pharmaceuticals in the U.S.;
- Spearheading a preferential treatment program or relief fund for U.S.-manufactured pharmaceuticals to include manufacturer rebates and discounts through CMS; or
- Investing in workforce development to spur onshore production of pharmaceuticals.

[16] *See*, for example, U.S. Gov't Accountability Off., GAO-11-365, End-Stage Renal Disease: CMS Should Assess Adequacy of Payment When Certain Oral Drugs Are Included and Ensure Availability of Quality Monitoring Data (2011); U.S. Gov't Accountability Off., GAO-10-295, End-Stage Renal Disease: CMS Should Monitor Access to and Quality of Dialysis Care Promptly after Implementation of New Bundled Payment System (2010).

X. Conclusion

For the reasons stated above, Kidney Care Partners urges the Bureau of Industry and Security to exclude the ESRD Pharmaceuticals identified in Appendix A from any tariffs or other trade measures imposed as a result of this Section 232 investigation. ESRD Pharmaceuticals are critical, life-saving medications necessary to the survival of Americans living with ESRD, a chronic, permanent condition. Loss of access to these Pharmaceuticals for even a short period of time could result in severe health consequences for ESRD patients, including death. Imposing tariffs or other trade measures on ESRD Pharmaceuticals would not support U.S. national security or foreign policy interests. Moreover, the relief requested by KCP—namely, excluding ESRD Pharmaceuticals from any trade action—is narrowly tailored and necessary to protect the ESRD population. Due to the importance of this issue for ESRD patients, KCP respectfully requests a meeting with BIS officials before any action is taken that would impact access to life-saving ESRD Pharmaceuticals.

Sincerely,

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Chair 2024-2025
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KIDNEY CARE PARTNERS

Appendix A: ESRD Pharmaceuticals

Section 1: Pharmaceuticals Necessary for Dialysis Treatment

Category	Title
Access Management	INJ HEPARIN SODIUM
	INJ HEPARIN SODIUM
	LEPIRIDUN
	RETEPLASE INJECTION
	ALTEPLASE RECOMBINANT
	UROKINA SE INJECTION
	UROKINA SE INJ
	INJ ARGATROBAN
	ARGATROBAN DIALYSIS, AUROMED
Anemia Management	DARBEPOETIN
	INJ. EPOETIN BETA (FOR ESRD ON DIALYSIS)
	VADADUSTAT, ORAL, (FOR ESRD ON DIALYSIS)
	INJ FERRIC CARBOXY MALTOSE
	FE PYRO CIT POW IRON
	IRON DEXTRAN
	INJ. FERRIC PYRO PHOSPHATE CIT
	IRON SUCROSE INJECTION
	NA FERRIC GLUCONATE COMPLEX
	VITAMIN B12 INJECTION
	FERUMOXYTOL
	EPO
	INJECTION, EPOETIN ALFA, BIOSIMILAR
Bone and Mineral Metabolism	SEVELAMER CARBONATE
	SEVELAMER CARBONATE PDR
	SEVELAMER HYDROCHLORIDE
	CINACALCET, ORAL, (FOR ESRD ON DIALYSIS)
	SUCROFERRIC OXYHYDROXIDE
	INJECTION, ETELCALCETIDE
	LANTHANUM CARBONATE ORAL

Category	Title
	LANTHANUM CARBONATE PWDR
	FERRIC CITRATE ORAL IRON
	CALCIUM GLUCONATE INJECTION
	CALCIUM ACETATE, ORAL
	CALCIUM GLYCER & LA CT
	CALCITONIN SALMON INJECTION
	INJ CALCITRIOL
	DEFEROXAMINE MESYLATE INJ
	INJECTION, DOXERCALCIFEROL
	IBANDRONATE SODIUM
	PAMIDRONATE DISODIUM
	PARICALCITOL
	ZOLEDRONIC ACID
Cellular Management	INJ LEVOCARNITINE PER
Anti-Infectives	DAPTOMYCIN
	INSTILLATION, TAUROLIDINE AND HEPARIN SODIUM (CENTRAL VENOUS CATHETER LOCK FOR ADULT PATIENTS RECEIVING CHRONIC HEMODIALYSIS)
	VANCOMYCIN HCL INJECTION
Composite Rate Drugs and Biologicals	INJ PROTAMINE SULFATE
	INJ MEPIVACAINE HYDROCHLORIDE
	INJECTION, DIFELIKEFALIN(FOR ESRD ON DIALYSIS)
	BROMPHE NIRAMINE MALEATE
	INJ DIPHEN HYDRAMINE HCL
	INJ CHLOROTHIAZIDE SODIUM
	INJ DIMENHYDRINATE
	INJ FUROSEMIDE
	INJ LIDOCAINE HCL FOR INTRAVENOUS INFUSION
	INJ MANNITOL
	INJECTION, ORPHENADRINE CITRATE
	INJ PROTAMINE SULFATE
	INJ ROPIVACAINE HYDROCHLORIDE
	INJ TORSEMIDE
	INJ HYDROXYZINE HCL
	INJ. POTASSIUM CHLORIDE
	INFUSION, NORMAL SALINE SOLUTION
	INFUSION, NORMAL SALINE SOLUTION, STERILE

Category	Title
	5% DEXTROSE/NORMAL SALINE
	INFUSION, NORMAL SALINE SOLUTION
	5% DEXTROSE/WATER
	INFUSION, D5W
	RINGERS LACTATE INFUSION
	HYPERTONIC SALINE SOL
	DIPHENHYDRAMINE HYDROCHLORIDE

Section 2: Pharmaceuticals Necessary for Kidney Transplant Treatment

Category	Title
Immunosuppression	TACROLIMUS (PROGRAF, ENVARSUS)
	MYCOPHENOLATE (CELLCEPT, MYFORTIC)
	AZATHIOPRINE (IMURAN)
	SIROLIMUS (RAPAMUNE)
	EVEROLIMUS (ZORTRESS)
	PREDNISONE
	BELATACEPT (NULOJIX)
	CYCLOSPORINE (NEORAL, SANDIMMUNE, GENGRAF)
	MYCOPHENOLATE (CELLCEPT, MYFORTIC)
	AZATHIOPRINE (IMURAN)
	SIROLIMUS (RAPAMUNE)
	EVEROLIMUS (ZORTRESS)
	PREDNISONE
	BELATACEPT (NULOJIX)
	CYCLOPHOSPHAMIDE
	RITUXIMAB
	ECULIZUMAB/RAVULIZUMAB
	IPTACOPAN
Induction Therapies	BASILIXIMAB (SIMULECT)
	THYMOGLOBULIN
	ALEMTUZUMAB (CAMPATH)
	PREDNISONE/METHYLPREDNISOLONE
Infection Prevention	TRIMETHOPRIM-SULFAMETHOXAZOLE (BACTRIM)
	VALGANCICLOVIR (VALCYTE)

Appendix B: KCP Signatories

Akebia Therapeutics, Inc.
American Kidney Fund
American Nephrology Nurses Association
American Society of Nephrology
American Society of Pediatric Nephrology
Ardelyx
Atlantic Dialysis Management Services, LLC
CorMedix, Inc.
CSL Vifor
DaVita, Inc.
Diality, Inc.
Dialysis Care Center
Dialysis Patient Citizens, Inc.
Fresenius Medical Care North America
Greenfield Health Systems
Kidney Care Council
Nephrology Nursing Certification Commission
North American Transplant Coordinators Organization
Pathalys Pharma, Inc.
Renal Healthcare Association
Renal Physicians Association
Renal Support Network
The Rogosin Institute
U.S. Renal Care
Unicycive Therapeutics, Inc.