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March 7, 2022

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Chiquita Brooks-LaSure
Administrator
Center for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

Dear Secretary Becerra and Administrator Brooks-LaSure:

The American Kidney Fund appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) proposed rule: Contract Year 2023 Policy and Technical Changes to the Medicare Advantage (MA) and Medicare Prescription Drug Benefit Programs

The American Kidney Fund (AKF) fights kidney disease on all fronts as the nation's leading kidney nonprofit. AKF works on behalf of the 37 million Americans living with kidney disease, and the millions more at risk, with an unmatched scope of programs that support people wherever they are in their fight against kidney disease—from prevention through transplant. Through programs of prevention, early detection, financial support, disease management, clinical research, innovation and advocacy, no kidney organization impacts more lives than AKF. AKF is one of the nation's top-rated nonprofits, investing 97 cents of every donated dollar in programs, and holds the highest 4-Star rating from Charity Navigator and the Platinum Seal of Transparency from GuideStar.

Restore MA network adequacy requirements for outpatient dialysis facilities

Although CMS does not address this issue in the proposed rule, AKF would like to reiterate our concern with the current policy that eliminated network adequacy requirements for outpatient dialysis facilities starting in 2021 and instead requires MA plans to attest to maintaining an adequate network of dialysis facilities. We believe this does not sufficiently ensure end-stage renal disease (ESRD)

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beneficiaries have equal access to MA plans as other Medicare beneficiaries. We, therefore, urge CMS to restore time and distance and minimum number of provider network adequacy standards for outpatient dialysis services.

Research has shown the connection between proximity to health care providers and facilities and better health outcomes for patients. This is especially true for dialysis patients, the majority of whom receive in-center dialysis and must travel to a dialysis facility three times a week. Studies have shown that when patients live or work closer to a provider, there is better adherence to prescribed dialysis treatments. The burden of longer travel times to facilities can lead to missed treatments and increased negative outcomes, including mortality, cardiac arrest, hospitalization, higher kidney disease burden, and higher levels of depression.

Eliminating time and distance and minimum number of provider network adequacy standards for outpatient dialysis services could make MA plans impractical for patients with ESRD and could effectively prohibit them from selecting an MA plan. The Medicare Payment Advisory Commission (MedPAC) has voiced this concern as well. MedPAC has noted that "MA coverage should be the same for ESRD beneficiaries as for all Medicare beneficiaries, and if plans were allowed to construct networks with a lesser degree of coverage for dialysis facilities than for other provider types, it could allow plans some ability to discriminate against ESRD beneficiaries wishing to enroll in MA."[1]

AKF strongly supports increased coverage options for ESRD patients, and we appreciate CMS' efforts in implementing the statutory change that allows ESRD beneficiaries to select an MA plan if they decide that is the best option for their needs. MA plans can offer additional benefits unavailable in traditional Medicare that can be important factors in a beneficiary's decision to enroll in MA, such as care coordination, vision and dental coverage, transportation, and an annual out-of-pocket maximum. The cap on out-of-pocket expenses is particularly important for beneficiaries who live in one of the twenty states that do not guarantee access to Medigap supplemental insurance for ESRD beneficiaries under the age of 65. These beneficiaries face financial hardship because they lack access to the supplemental coverage needed to help pay the cost-sharing in traditional Medicare, which does not have an annual out of-pocket spending limit.

However, because of their ESRD and the comorbidities that occur more commonly for people with kidney disease, CMS must ensure regulatory policies result in meaningful access to MA plans and do not effectively lead to discouraging ESRD patients from enrolling in MA plans.

Lowering Beneficiary Cost-Sharing at the Pharmacy Counter

For many Americans, particularly those with chronic conditions such as kidney disease and who may have multiple comorbidities, the rising cost of prescription drugs can create a significant financial burden that can affect their medication adherence and overall health. AKF is supportive of policies that effectively balance the need to lower patient costs, protect patient access to needed medications, promote competition and innovation, and ensure patient safety. Therefore, AKF

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[1] Medicare Payment Advisory Commission, *The Medicare Advantage program: Status report*, March 2021. https://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch12_sec.pdf

supports the goal of CMS' proposed policy that would require Part D plans to apply all price concessions they receive from network pharmacies to the point of sale, so that the beneficiary can also share in the savings. We also encourage CMS to explore a policy that would utilize manufacturer rebates for reducing beneficiary out-of-pocket costs at the point of sale, which could further reduce the cost burden for beneficiaries and ensure they can adhere to their medication treatments.

We also recommend CMS amend their proposal and apply pharmacy price concessions for applicable drugs across all phases of the Part D benefit, including the coverage gap. As noted in the proposed rule, CMS believes that doing so would be consistent with statute, and we believe it will mitigate beneficiary confusion and allow them to access consistent, lower out-of-pocket expenses across all phases of the Part D benefit.

Thank you for the opportunity to provide comments on this proposed rule.

Sincerely,

LaVarne A. Burton
President and CEO