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August 31, 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: CMS-4203-NC: Medicare Program; Request for Information on Medicare

Dear Secretary Becerra and Administrator Brooks-LaSure:

The American Kidney Fund appreciates the opportunity to provide comments on CMS' request for information on various aspects of the Medicare Advantage (MA) program.

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.

AKF supports CMS' Vision for Medicare that "puts the person at the center of care and drives towards a future where people with Medicare receive more equitable, high quality, and whole-person care that is affordable and sustainable." We also appreciate that CMS is seeking feedback through this RFI on ways to strengthen the MA program that align with CMS' Vision for Medicare and its strategic pillars. Advancing health equity and ensuring high

quality and affordable care in the MA program is particularly important for Medicare beneficiaries with end-stage renal disease (ESRD), who, when compared to non-ESRD Medicare beneficiaries, have larger proportions of people who are dually eligible for Medicare and Medicaid; are from racial or ethnic minority groups; are under the age of 65; and are more likely to live in socioeconomically disadvantaged neighborhoods.

Ensuing health equity and high quality care in MA is also imperative as more ESRD beneficiaries choose to enroll in an MA plan. An analysis showed that the proportion of all ESRD patients enrolled in MA grew from 22.7% in December 2020 to 30.3% in January 2021, the coverage effective date for plans chosen during the previous open enrollment period, which was the first opportunity for all Medicare ESRD beneficiaries 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 has allowed all Medicare ESRD beneficiaries to have the option of selecting 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.

AKF provides the following comments to specific questions in the RFI that have the most relevance for people with ESRD.

A. Advance Health Equity

Q1: What steps should CMS take to better ensure that all MA enrollees receive the care they need, including but not limited to the following:

- **Enrollees from racial and ethnic minority groups...**
- **Enrollees with disabilities, frailty, other serious health conditions, or who are nearing end of life...**
- **Enrollees of disadvantaged socioeconomic status...**
- **Enrollees who live in rural or other underserved communities.**

Q2: What are examples of policies, programs, and innovations that can advance health equity in MA? How could CMS support the development and/or expansion of these efforts and what data could better inform this work?

¹ Avalere Health, "ESRD Enrollment in MA Now Exceeds 30 Percent of all Dialysis Patients," December 16, 2021: <https://avalere.com/insights/esrd-enrollment-in-ma-now-exceeds-30-percent-of-all-dialysis-patients>

To ensure that all MA enrollees with ESRD receive the care they need and to advance health equity in MA, CMS needs to ensure there is parity in access to innovative products for all ESRD beneficiaries in MA or Medicare fee-for-service (FFS). CMS has indicated in the past that they consider various trends when calculating MA ESRD payment rates, including changes in coverage through regulation. However, because those payment projections use previous years' costs, they do not accurately anticipate new drugs and devices that enter the market. This is especially true for drugs that receive the Transitional Drug Add-on Payment Adjustment (TDAPA) or the Transitional Add-on Payment Adjustment for New and Innovative Equipment and Suppliers (TPNIES). It is difficult to know when products will receive TDAPA or TPNIES and what the utilization and cost will be. The experience with calcimimetics during its TDAPA period demonstrated this shortcoming, as it became clear that MA plans were not accounting for this new product that was receiving TDAPA in FFS.

To ensure ESRD beneficiaries in MA have access to new and innovative products that are receiving TDAPA or TPNIES and are available to ESRD beneficiaries in FFS, CMS needs to address this issue. We urge CMS to work with stakeholders to develop a solution that safeguards access to innovative products for all ESRD beneficiaries, whether they receive their coverage through MA or FFS.

B. Expand Access: Coverage and Care

Q6: What factors do MA plans consider when determining whether to make changes to their networks? How could current network adequacy requirements be updated to further support enrollee access to primary care, behavioral health services, and a wide range of specialty services? Are there access requirements from other federal health insurance options, such as Medicaid or the Affordable Care Act Marketplaces, with which MA could better align?

AKF remains concerned 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 ESRD beneficiaries have equal access to MA plans as other Medicare beneficiaries. Although many individuals with ESRD selected MA plans in 2021, many could be discouraged from enrolling in an MA plan without a specific requirement that plans include outpatient dialysis as part of their in-network services. 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.²

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.”³

Restoring network adequacy standards for outpatient dialysis services is also important for advancing health equity in the MA program. Because the Medicare ESRD population who require dialysis has a higher proportion of people who are from racial and ethnic minority groups, are lower income, and live in underserved areas, eliminating network adequacy requirements for outpatient dialysis serves as a proxy for restricting access to MA plans.

Thank you for the opportunity to provide comments on this RFI. If you have questions on our response or would like to further discuss these issues, please contact me at hbode@kidneyfund.org.

Sincerely,



Holly Bode

Vice President of Government Affairs

² Salmi, A.; Larkina, M; Wang, *et al* “Missed Hemodialysis Treatments: International Variation, Predictors, and Outcomes in the Dialysis Outcomes and Practice Patterns Study (DOPPS).” *72 Am J Kidney Dis.* 634-43 (Nov. 2018).

³ 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