



Service to those affected by chronic kidney disease

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April 6, 2020

The Honorable Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Administrator Verma:

**RE:** Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

Renal Support Network (RSN) is a nonprofit, patient-focused organization dedicated to helping improve the lives of people living with kidney disease. As President and Founder of RSN, it was my goal to give people living with chronic kidney disease (CKD) the tools to effectively take control of the course and management of this life-threatening illness through education and engagement programs. I have lived with CKD since 1968 at the age of two, am doing well on my 4<sup>th</sup> kidney transplant, and have witnessed firsthand the evolution of the End Stage Renal Disease (ESRD) program.

CKD affects over 30 million people in the United States and has been recognized as an emerging epidemic that disproportionately affects the economically disadvantaged and minorities. Over 661,000 people require regular dialysis or a kidney transplant to live. And the quality of care we receive directly affects our life expectancy, quality of life and contributions to society. RSN allows my peers to have hope, learn about their illness and be proactive in their care.

Across the industry, there has been a major push to provide more options for patients with chronic kidney disease. We at RSN are always promoting ways to make the lives of people living with chronic kidney disease easier. Thank you for the opportunity to comment on the Medicare Advantage (MA) part of this rule as it impacts people living with ESRD.

We were encouraged when *the 21st Century Cures Act* amended the *Social Security Act* to allow all Medicare-eligible individuals with ESRD to enroll in Medicare Advantage (MA) plans beginning January 1, 2021. With this new enrollment option, there will also be related payment changes in the MA and Fee-For-Service (FFS) programs, which can potentially be beneficial for the ESRD community.

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An illness is too demanding when you don't have hope!

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Part of the reason ESRD patients were originally excluded from MA is because they are the only disease-specific form of Medicare recipients, making it difficult territory to navigate. Patients with ESRD require substantial and immediate health care and financial resources, as they usually need some form of dialysis and frequent doctor visits. While a positive prospect, because it's new territory, MA as an option for the ESRD population causes some concern, which I will briefly elaborate on.

“All-In-One” managed care systems like Medicare Advantage have soared in popularity in recent decades due to their promise of reduced health care costs and superior quality of care. It attempts to achieve these goals by emphasizing preventive care, requiring patients to receive care from a network of participating providers, and coordinating the care of patients with complex or chronic health conditions. MA may be well-suited to provide high-value care to the costly and complex needs of the ESRD community because of the coverage and care it offers to chronically ill beneficiaries including options for chronic disease management.

We appreciate that once the rule goes into effect January 1, 2021 MA organizations will no longer be responsible for organ acquisition costs for kidney transplants for MA beneficiaries, and such costs will be excluded from MA benchmarks and covered under the fee-for-service program, allowing for money to be moved to other areas. But what if costs are not effectively covered and access to benefits and care is jeopardized?

Contrary to many who feel ESRD patients were pushed aside or overlooked as only a financial burden when Managed Care was first introduced, RSN believes it was a compassionate decision and not discrimination. There is a very specific complexity to living and dealing with ESRD and in order to provide the most benefit, understanding those needs with as much accuracy as possible is vital. At the time of its inception managed care was not a well-oiled machine, thus including ESRD patients could have led to problems with the timeliness of care, among other things. And this still applies; inadequate networks and waiting for appointments could have dire consequences. As ESRD patients are blended into the program and additional costs arise, this may fall on patients in the form of lack of care and lack of access because the system is flooded and unprepared.

In many ways, Medicare Advantage is comparable to “privatizing” Medicare. And there are a lot of problems with doing that. We've seen that in many cases private health plans have incentives to “underprovide” people who get sick -- incentives that are created by ill-considered government regulation. And with ESRD patients already being “sick” and needing more care and maintenance than the average Medicare recipient, not only have we repeatedly seen that private MA plans cost more than traditional FFS Medicare, they are also more cumbersome to navigate in terms of beneficiaries receiving the quality care and treatment to which they're entitled.

However, a plan like MA can be advantageous if implemented correctly. If MA plans are further expanding benefits that make it preferable to a traditional FFS plan, like office care coordination services, transportation to appointments, over-the-counter medication, education services, mental health care, dental coverage (critical to get on the transplant list) and other services like home improvements that ensures beneficiary safety, ESRD patients would greatly benefit. As RSN states often, value-based care can

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also reduce hospital readmissions and enable the older and most vulnerable patients to stay healthy at home instead of in a medical facility.

It would also require a sufficient network of appropriate and available providers for the ESRD population. CMS provides guidance to plans on agency measures and assesses the adequacy of an MA's network, and it must maintain enough specified providers/facilities to ensure that 90 percent of beneficiaries have access to at least one provider/facility of each specialty type within published maximum time and distance standards. This is critical, because if there's a shortage, within a short period of time patients, particularly dialysis patients, will feel the impact.

This rule will also allow for a change in prescription drug pricing, giving Part D plans the ability to negotiate pricing, promoting less expensive generic drugs and allowing patients to compare drug prices for the one that best fits their needs and wallet. No varying copays for medications and appointments would be a positive benefit. But if copays are not preestablished, this could be bad for numerous ESRD patients. Maximum out-of-pocket costs should be established to prevent insurance companies from cherry-picking and thereby making their prices unreasonably high, which only hurts patients.

The ESRD Prospective Payment System (PPS) sets the foundation of the MA ESRD rates. It is recommended that CMS review the MA ESRD rates and use its power to raise them and to address the chronic underfunding in the ESRD PPS. This is necessary to ensure the costs of services provided, especially dialysis, is covered. In addition, innovation payment needs to be addressed and payment structures in place to allow new therapies to be created and available.

As MA becomes more inclusive, it stands to reason that enrollment will increase each year. Within a few years it could even be the dominant form of Medicare. Even though the actual coverage doesn't start until 2021, it will become available in next season's open enrollment period, which means MA plans should be currently considering ways to serve ESRD populations in order to be in a position to offer these complex expanded benefits in time. It is pivotal to prepare well in advance for an influx of members to effectively manage the new and growing ESRD population.

It's also important to factor in the needs of rural ESRD patients and patients who rely on family to get to providers and necessary treatment like dialysis centers. There are less plan providers in rural areas, and transportation concerns in both rural and urban areas. But plans in areas with the highest ESRD population may be underpaid, and if that's the case, without adequate payment MA plans may be forced to raise consumer costs, reduce supplemental benefits, or limit service areas - and that is too high a cost for ESRD patients.

If they're basing funding initiatives on statistics from ESRD patients already on MA, they may be flawed because in order to qualify they had to have special circumstances, which often means more costly circumstances. There is a probability the current ESRD payment model fails to account for state-wide treatment cost variations and that has serious implications for our community. Which leads to MA plans experiencing significant ESRD reimbursement rate fluctuations. Historically, in urban areas with high Medicare Advantage penetration, Medicare Advantage plans were underpaid and that was without people on dialysis.

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Both patients and the MA plans will benefit from Telehealth coverage. In 2019, CMS finalized requirements for MA plans offering additional Telehealth benefits. Also, the Covid-19 Crisis is increasing access to Telehealth to meet the healthcare gap. The Bipartisan Budget Act of 2018 authorized MA plans to offer additional telehealth benefits beginning with the 2020 plan year and to treat these additional benefits as basic rather than supplemental benefits. This will greatly help rural, disabled and assistance-reliant ESRD patients.

It's important for patients to have flexibility because of the unknowns involved. For example, if people sign up for MA and they realize it isn't the option for them, they should be able to have the ability to modify/switch plans or to cancel. It's important for people to not be locked into an MA plan, this is a disservice to both CMS and patients. Also, there should be some kind of oversight and penalty for companies who use aggressive marketing campaigns to recruit ESRD patients and "bait and switch" with services the beneficiary was promised and not delivered.

As it stands, Medicare only covers kidney transplant patients for 36 months after transplant. It would be a great service to (former) ESRD patients on Managed Care programs who reach the 36-month of a kidney transplant mark to be able to continue with the insurance provider in order to maintain continuity and access to care. This will only be a feasible option if the insurance provider agrees to a standard rate upon enrolling. In the ESRD community, continuity of care leads to better care quality outcomes, survival rates and lower costs for plans and patients.

In conclusion, a switch to Medicare Advantage plans for people living with ESRD can be a positive if implemented with the proper research and provisions in place to ensure continual coverage and protections in place for the large number of ESRD patients who may enroll. But unless there are proven guarantees, it may behoove CMS to roll out this rule slowly and carefully so as not to overwhelm the system at the patient's expense. Thank you for allowing RSN to express our concerns on behalf of people who have kidney disease.

Sincerely,



Lori Hartwell  
President/Founder