American Kidney Fund®
FIGHTING ON ALL FRONTS

January 5, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications; proposed rule

Dear Administrator Brooks-LaSure:

The American Kidney Fund appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Service's (CMS) Medicare Advantage and Medicare Part D proposed rule for contract year (CY) 2025, referenced above.

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 strongly supports increased coverage options for people with end-stage renal disease (ESRD), and we appreciate CMS's efforts in implementing the statutory change that has allowed all Medicare ESRD beneficiaries to have the option of selecting a Medicare Advantage (MA) plan if they decide that is the best option for their needs. The share of Medicare ESRD beneficiaries enrolled in MA has increased significantly since 2021, the first year all ESRD beneficiaries were allowed to enroll in MA. In December 2020 the share of ESRD beneficiaries enrolled in MA was 27 percent; by December 2022 it was 47 percent.[1] Given the growing enrollment in MA among ESRD beneficiaries, ensuring they have access to quality care and necessary services in the MA program is critical.

[1] https://www.medpac.gov/wp-content/uploads/2023/03/Dialysis-Dec-2023-SEC.pdf

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Improving Access to Behavioral Health Care Providers

AKF supports CMS's proposal to add Outpatient Behavioral Health as a new type of facility-specialty and to add it to the time and distance requirements for MA organizations. We consistently hear from people living with kidney disease that a critical aspect of their care that needs to be addressed is their mental and behavioral health. Kidney disease takes a physical toll on a person's body, and the stressors related to managing and treating kidney disease can affect a person's mental and emotional well-being. It is not uncommon for people living with kidney disease to also have depression, anxiety or struggle with substance use disorders. Therefore, we commend CMS for its commitment to improving access to behavioral health services for enrollees in the MA program.

Given the importance of network adequacy requirements and time and distance standards to ensure MA enrollees have access to needed services and providers, we want to reiterate our previous concerns with the CMS policy that eliminated network adequacy requirements for outpatient dialysis facilities and other kidney care providers. We have heard from stakeholders in the kidney community that some patients in MA have faced difficulty accessing kidney care providers near their home. While we appreciate that CMS has stated it will monitor MA enrollee access to kidney care providers through account management activities, complaint tracking and reporting, and auditing activities, we believe including dialysis facilities, nephologists, and vascular access surgeons in network adequacy requirements is a more efficient and effective way to ensure access to kidney care services, especially for the beneficiary.

Special Supplemental Benefits for the Chronically Ill (SSBCI)

AKF supports CMS's proposed regulatory changes that would help ensure benefits offered as SSBCI are appropriate and reasonably expected to improve or maintain the health or overall function of chronically ill MA enrollees, which can include people with ESRD. We also support CMS's proposed changes to the marketing and communication requirements for SSBCI, which aim to protect beneficiaries and improve transparency regarding SSBCI so that beneficiaries are aware that SSBCI are only available to enrollees who meet specific eligibility criteria.

SSBCI can help address gaps in care, particularly related to social determinants of health, that can lead to improved health outcomes for people with chronic conditions and other comorbidities. SSBCI offered by MA plans is also a key factor that many beneficiaries consider when deciding to enroll in an MA plan. The proposed requirements for MA plans to demonstrate that SSBCI items and services meet the statutory threshold of having a reasonable expectation of improving or maintaining the health or overall function of chronically ill enrollees—and supported by research—will help protect beneficiaries from being offered SSBCI that are not appropriate for their care. We also believe that the proposed marketing requirements that would strengthen the SSBCI disclaimer will help increase transparency for beneficiaries and hopefully decrease misleading advertising by MA organizations.

Mid-Year Enrollee Notification of Available Supplemental Benefits

AKF supports the proposed requirement for MA plans to annually issue a mid-year notification to enrollees of the unused supplemental benefits available to them, which would include the scope of the benefit, cost-sharing, instructions on how to access the benefit, any network application information for each available benefit, and a customer service number to call if additional help is needed. As noted above, supplemental benefits offered and marketed by MA organizations can play a key factor in a beneficiary's decision to enroll in an MA plan. But as CMS notes in the preamble, reports have indicated low utilization of supplemental benefits by MA enrollees. We believe the proposed mid-year notification will help make enrollees more aware of the supplemental benefits that are available to them and make MA organizations more accountable for using taxpayer-funded rebate dollars to provide the supplemental benefits, and not use the benefits primarily as a marketing tool.

Enhance Guardrails for Agent and Broker Compensation

AKF strongly supports CMS's proposals that would generally prohibit contract terms between MA organizations and agents, brokers or other third party marketing organizations (TPMOs) that may interfere with the agent's or broker's ability to objectively assess and recommend the plan that best fits a beneficiary's health care needs; set a single compensation rate for all plans; revise the scope of items and services included within agent and broker compensation; and eliminate the regulatory framework which currently allows for separate payment to agents and brokers for administrative services. For beneficiaries who want to enroll in an MA plan, particularly those with chronic kidney disease or ESRD, choosing the most appropriate plan for their chronic condition and other comorbidities is a critical decision. We appreciate CMS's continued efforts to make needed changes to the broker and agent compensation structure to ensure beneficiaries enroll in the MA plan that best fits their health care needs.

Annual Health Equity Analysis of Utilization Management (UM) Policies and Procedures

AKF strongly supports the proposals to require that a member of an MA organization's UM committee have expertise in health equity, and to require the UM committee conduct an annual health equity analysis of the use of prior authorization. We support CMS's proposal that the health equity analysis examine the impact of prior authorization on enrollees with social risk factors including receipt of the Part D low-income subsidy (LIS) or being dually-eligible for Medicare and Medicaid, or having a disability.

We recommend that CMS consider requiring the health equity analysis to examine the impact of prior authorization on members of racial and ethnic communities, individuals with limited English proficiency, and members of rural communities. We also recommend that CMS consider requiring UM committees to disaggregate in their health equity analysis the impact of prior authorization or other UM policies on kidney care services, including dialysis treatments and transplant. This information would be particularly informative given that all ESRD beneficiaries

have only been able to enroll in an MA plan since 2021, and the subsequent growth in the share of Medicare ESRD beneficiaries enrolled in MA.

Amendments to Part C and Part D Reporting Requirements

AKF appreciates and supports CMS's proposal to affirm its authority to collect detailed information from MA organizations and Part D plan sponsors under current regulations. We urge CMS to use this authority to collect additional data from MA organizations and require them to submit the same data that is collected and reported in the U.S. Renal Data System (USRDS) for the fee-for-service (FFS) Medicare ESRD program. The USRDS data set and annual report has been a key tool for researchers and policymakers in examining the population of ESRD beneficiaries in Medicare FFS, but there is not a parallel data set for ESRD beneficiaries in MA, which is now approaching 50 percent of ESRD beneficiaries. Having the same types of data in the USRDS for FFS and MA enrollees is essential to accurately tracking trends in the ESRD population.

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

Sincerely,

Holly Bode
Vice President of Government Affairs