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Nonprofit Kidney Care Alliance

January 16, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-4182-P: Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program, November 28, 2017.

Dear Administrator Verma:

On behalf of the Nonprofit Kidney Care Alliance (NKCA), we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Medicare Advantage (MA) and Part D Proposed Rule. NKCA represents five nonprofit dialysis providers: Centers for Dialysis Care; Dialysis Clinic, Inc. (DCI); Independent Dialysis Foundation, Inc.; Northwest Kidney Centers; and The Rogosin Institute. Collectively, we serve over 20,000 patients at more than 280 clinics in 30 states. Consistent with our belief that we can do more to keep patients *off dialysis*, we also serve more than 5,000 patients with chronic kidney disease (CKD), with the goal of avoiding, or at least delaying, onset of end stage renal disease (ESRD), and increasing the number of patients who can benefit from kidney transplants. Approximately 85 percent of our patients are covered by Medicare, including Medicare Advantage plans. Four of our five members also participate in the Comprehensive ESRD Care (CEC) Model through the Centers for Medicare and Medicaid Innovation (CMMI). Collectively, we are responsible for 9 ESRD Seamless Care Organizations (ESCOs) across the country in both one-sided and two-sided risk models.

We have two comments on the Proposed Rule, detailed below.

Comments Regarding Specific Provisions of the MA and Part D Proposed Rule

1. **<u>Opt-In Enrollment of Newly Eligible Beneficiaries in a Parent Company MA Plan</u>**

   CMS proposes to strengthen Medicare beneficiary safeguards for those who choose to opt-in to a Medicare Advantage plan offered by the same parent company as they are currently enrolled in (e.g., a commercial, employer-based plan) when they first become Medicare eligible. For over a decade—largely through sub-regulatory guidance—CMS has permitted MA plans to

conduct seamless enrollment of individuals as they first become eligible for Medicare by virtue of age or disability. However, as CMS notes, in the past few years, there have been concerns that some individuals who were auto-enrolled were not aware that their enrollment was occurring, even though there were requirements in place to enable the beneficiary to decline. Accordingly, CMS now proposes to strengthen beneficiary safeguards by making it clear that as part of their initial enrollment decision-making, the individual must ***opt-in***. Moreover, this opt-in process only applies to an MA plan sponsored by the same parent organization as the plan that they are currently enrolled in.

We agree with CMS that "a positive election … provides an additional beneficiary protection for non-dually eligible individuals, so that they may actively choose a Medicare plan." We support these proposed measures not only because Medicare beneficiaries should always have the choice of whether to enroll in fee-for service or Medicare Advantage, but also because an informed beneficiary making an active choice will deter churning.

2. <u>Default Enrollment of Dual Eligibles in MA Organizations</u>

CMS proposes to strengthen procedures related to default enrollment for dual-eligible beneficiaries into dual-eligible special needs plans (D-SNPs). Default enrollment of dual eligibles into D-SNPs has been allowed since the advent of the Medicare Part D program, yet beneficiary safeguards have not been spelled out. CMS proposes several safeguards, notably specific requirements for beneficiary notification prior to being enrolled into a Medicare Advantage D-SNP. Equally, if not more, important, CMS limits who can be default enrolled (or "seamlessly enrolled") to those dual eligibles who are already enrolled in a Medicaid Managed Care Organization (MCO) operated by the same parent company when they first become eligible for Medicare due to age or disability. CMS bases this proposal on the assumption that this will help promote integrated, quality care since the plan will already have experience with and data on the beneficiary and the beneficiary will have had experience with the plan company and will be better able to judge whether to exercise their right to opt out.

We believe that these are important safeguards, but we would urge CMS to better protect beneficiary choice. CMS asks whether a longer period in which a dual-eligible beneficiary can choose to opt-out should be included. We recommend, instead that dual eligibles be provided the same *opt-in* safeguards as CMS proposes for newly eligible beneficiaries in a parent company's MA plan. We believe *all* Medicare beneficiaries should have the right to choose their care and insurance, and not just be offered the option to opt-out of auto-enrollment.

Conclusion

Thank you for the opportunity to comment on the Medicare Advantage and Part D Proposed Rule. NKCA appreciates the opportunity to provide input to ensure that the rule's impact continues to support quality of care to the patients we serve. We would be pleased to discuss any of these suggestions in greater detail at any time. If you have any questions, please feel free to contact me at 202-580-7707 or info@nonprofitkidneycare.org.

Sincerely,

Martin Corry
Executive Director