



NATIONAL KIDNEY
FOUNDATION®

30 E. 33rd Street
New York, NY 10016
212.889.2210

July 1, 2023

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

The Honorable Chiquita Brooks-LaSure
Administrator Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Medicaid Program; Ensuring Access to Medicaid Services; Proposed Rule [CMS-2442-P]

Dear Secretary Becerra and Administrator Brookes-LaSure,

The National Kidney Foundation (NKF) thanks the Centers for Medicare & Medicaid Services (CMS) for the opportunity to provide comments on the Medicaid Program; Ensuring Access to Medicaid Services; Proposed Rule [CMS-2442-P]. NKF commends Agency efforts to increase transparency and accountability in the Medicaid program across fee-for-service (FFS), managed care delivery systems, and in home and community-based services (HCBS) programs. Further, we value the alignment of a comprehensive approach to improve access to care, quality and health outcomes, and achieve health equity. Our specific comments pertain to the advocacy of patients with kidney disease who rely on Medicaid coverage to have timely preventative services and diagnoses, efficient concordant care, and equitable access to life-saving treatment. NKF is the largest, most comprehensive and longstanding, patient centric organization dedicated to the awareness, prevention, and treatment of kidney disease in the U.S.

Access to Care

More than 37 million Americans have chronic kidney disease (CKD), including nearly 800,000 with irreversible kidney failure. Another 80 million Americans are at risk for developing kidney disease from hypertension, diabetes, and other risk factors. Unfortunately, 90 percent of those with CKD have not been diagnosed. Kidney disease is the tenth leading cause of death in the United States, causing more deaths than widely known cancers such as breast and prostate cancer. Stark inequities associated with worsening CKD progression into End Stage Renal Disease (ESRD) disproportionately affect diverse populations because of incongruent referrals for nephrology care and evaluations for various dialysis modalities and transplantation. Black individuals are affected at a rate “nearly double that of Hispanic

individuals, nearly triple that of Asian individuals, and more than quadruple that of White individuals.”¹

A significant mediator of disparities in kidney disease is access to financial resources to cover the innumerable costs of complex care, often seen within structurally disadvantaged populations. Many patients with kidney disease experience exponential financial burdens requiring them to rely on federal and state subsidies and welfare programs, such as Medicaid, in addition to the Medicare ESRD benefit. Unfortunately, systematic barriers for kidney patients with Medicare-Medicaid dual eligibility status have been found to correlate with a lower likelihood of care, ultimately resulting in an increased progression to kidney failure.² In 2018, ESRD beneficiaries made up about 1 percent of total Medicare enrollment and 2.5 percent of dual-eligible enrollment.³ Per-patient annual expenditures for dual-eligible kidney patients are \$94,253, higher than expenditures for patients enrolled in Medicare Advantage plans (\$75,263) or with Medicare coverage only (\$65,817).⁴ Beyond costs, differences in patient experience persist between dual and non-dual beneficiaries, especially among patients with kidney failure. An analysis of dual-eligible beneficiaries in Pennsylvania found that duals with ESRD had higher rates of negative outcomes, such as hospitalization and skilled nursing facility admissions, than Medicare-only beneficiaries but were less likely to experience positive outcomes like access to home dialysis.⁵ Finally, the unmet social needs that are common among dually eligible populations are often exacerbated among people with kidney disease, such as food insecurity, housing insecurity, transportation insecurity, and utility insecurity (energy, water, and electricity).

The unwinding of Medicaid continuous enrollment set forth by the Consolidated Appropriations Act (CAA) is posited to worsen existing disparities in healthcare access, quality, and outcomes for individuals with kidney disease, particularly among racial and ethnic minorities and low-income populations who are more likely to rely on Medicaid. The loss of access to essential services, such as preventative screening and treatment coverage, could be devastating. Significant out-of-pocket expenses could create an exorbitant financial burden on kidney patients, their families, and caregivers, leading to financial hardship such as medical debt and potential bankruptcy. As of June 29, 2023, twenty-six states and the District of Columbia have reported disenrolling at least 1,536,000 Medicaid enrollees, according to the Kaiser Family Foundation. The use of guideline-concordant, non-invasive

¹ United States Renal Data System. 2022 USRDS Annual Data Report: Epidemiology of kidney disease in the United States. National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2022.

<https://usrds-adr.niddk.nih.gov/2022>

² *Id.*

³ *Id.*

⁴ United States Renal Data System. 2022 USRDS Annual Data Report: Epidemiology of kidney disease in the United States. National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2022.

<https://usrds-adr.niddk.nih.gov/2022/end-stage-renal-disease/9-healthcare-expenditures-for-persons-with-esrd>

⁵ United States Renal Data System. 2022 USRDS Annual Data Report: Epidemiology of kidney disease in the United States. National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2022.

<https://usrds-adr.niddk.nih.gov/2022>

testing to assess kidney function via eGFR and albumin-to-creatinine ratio (uACR) is a crucial step towards improving American population health; it has proven to save healthcare costs downstream.⁶⁻⁷

Though access to healthcare is not a sole cure-all for patients with kidney disease, continued expansion of Medicaid, rejection of Medicaid work requirements, and support for policies that encourage enrollment in the Affordable Care Act (ACA) market plans are of paramount importance in preventing and slowing the progression of CKD to ESRD. States with more robust Medicaid coverage have a lower incidence of kidney failure.⁸ One population that is particularly vulnerable to the currently segmented system across states without expanded Medicaid coverage is undocumented immigrants. Undocumented immigrants are neither eligible for Medicare nor the financial subsidies that are often required to purchase ACA health insurance plans. There are between 5,000 – 9,000 undocumented people with kidney failure living in the U.S.⁹ Compared to U.S. citizens with kidney failure or ESRD, this population tends to be younger, Latino, have fewer comorbidities, and is largely uninsured. Under the Emergency Medical Treatment and Active Labor Act (EMTALA), hospitals are required to treat anyone with an emergency medical condition. In many states, the emergency department is virtually the only safety-net available to undocumented people with kidney failure. State governments are solely responsible for the expenditures associated with emergency-only dialysis, which can be as high as \$400,000 per person per year, resulting in a major burden on very limited hospital dialysis resources as well as hospital staff.¹⁰ In states that have adopted a standardized, outpatient-dialysis care approach, estimated savings are around \$17 million per year.¹¹ Expansion of emergency Medicaid to undocumented people with kidney failure to specifically cover vascular access procedures, outpatient maintenance dialysis (scheduled hemodialysis delivered at least three times a week), or peritoneal dialysis daily in the home is vitally important and should be enacted swiftly.

⁶ Stempniewicz, N., Vassalotti, J., Cuddeback, J., et al. Chronic Kidney Disease Testing Among Primary Care Patients With Type 2 Diabetes Across 24 U.S. Health Care Organizations. *Diabetes Care*. 2021; 44(9): 2000–2009. <https://doi.org/10.2337/dc20-2715>

⁷ Cusick, M., Tisdale, R., Chertow, G., et al. Population-Wide Screening for Chronic Kidney Disease: A Cost-Effectiveness Analysis. *Ann Intern Med*. 2023; 176(6): 788–797. <https://doi.org/10.7326/M22-3228>

⁸ Kurella-Tamura, M., Goldstein, B., Hall, Y., et al. State Medicaid Coverage, ESRD Incidence, and Access to Care. *J Am Soc Nephrol*. 2014; 25(6):1321–1329. <https://doi.org/10.1681/ASN.2013060658>

⁹ Rodriguez, R., Cervantes, L., Raghavan, R. Estimating the Prevalence of Undocumented Immigrants with End-Stage Renal Disease in the United States. *Clinical Nephrology*. 2020; 93(1):108–112. <https://doi.org/10.5414/cnp92s119>

¹⁰ Shafiqat, F., Das, S., Wheatley, M., et al. The Impact of “Emergency-only” Hemodialysis on Hospital Cost and Resource Utilization. *Western Journal of Emergency Medicine*. 2023; 24(2):206–209. <https://doi.org/10.5811/westjem.2022.11.58360>

¹¹ Brown J. Immigrants here illegally were waiting until near death to get dialysis. A new Colorado policy changes that. The Colorado Sun. 2019 Feb 25. Retrieved from: <https://coloradosun.com/2019/02/25/undocumented-immigrants-dialysis-colorado-medicaid-policy/>

Quality and Health Outcomes

Access to kidney transplantation is crucial for individuals diagnosed with advanced CKD and ESRD. It is the optimal therapy for survival and leads to better quality of life and reduced healthcare costs.¹² Recent data from the United States Renal Data System (USRDS) annual data report shows that racial/ethnic groups living in neighborhoods with higher social deprivation index (SDI) scores (indicating higher social deprivation) were substantially less likely to have been preemptively waitlisted or to have received a kidney transplant. White and Black patients living in the most deprived neighborhoods were almost 40 percent and Hispanic patients over 30 percent less likely to receive a deceased donor kidney transplant than those living in the least deprived neighborhoods. Additionally, because transplantation is the optimal treatment for kidney failure, we strongly advocate for Medicaid programs to provide coverage for both kidney and pancreas transplantation for kidney failure patients with diabetes. Evidence shows that Simultaneous Pancreas/Kidney (SPK) transplantation can improve both kidney graft and patient survival in comparison to kidney transplantation alone.¹³

In closing, NKF reiterates our appreciation for your leadership in the care of some of our nation's most vulnerable populations. We are committed to the continued focus on the epidemic of kidney disease and innovative health policies that create equity, dignified care delivery, and a healthcare system accountable for the timeliness and quality of care.

The National Kidney Foundation appreciates the opportunity to provide comments to CMS on the Medicaid Program; Ensuring Access to Medicaid Services; Proposed Rule. Improved outcomes for kidney patients and patients at-risk rely on prevention, early detection, efforts to slow or stop the progression of kidney disease, and increased access to kidney transplantation. We welcome the prospect of providing additional insight on future policy initiatives regarding these matters. Please contact Ivory Harding, Director of Quality and Regulatory Affairs, at Ivory.Harding@kidney.org with any questions or concerns.

Sincerely,



Kevin Longino
CEO and Transplant Recipient



Sylvia Rosas, MD
President

¹² Iqbal, M., Rahman, N., Alam, M. et al. Quality of Life Is Improved in Renal Transplant Recipients Versus That Shown in Patients With Chronic Kidney Disease With or Without Dialysis. *Exp Clin Transplant*. 2020; 18(1):64-67.

<https://doi.org/10.6002/ect.TOND-TDTD2019.P11>

¹³ Penn Medicine. Simultaneous Pancreas / Kidney Transplantation at the Penn Transplant Institute [Internet]. Philadelphia(PA): University of Pennsylvania Health System. 2002 Oct 10 [cited 2023 Jun 30]. Available from: <https://www.pennmedicine.org/for-health-care-professionals/for-physicians/physician-education-and-resources/clinical-briefings/2022/october/simultaneous-pancreas-kidney-transplantation-at-the-penn-transplant-institute>