Medicaid RFI Draft Comments on
CMS Request for Information: Access to Coverage and Care in Medicaid & CHIP

On February 17, the Centers for Medicare and Medicaid Services released a request for information (RFI) soliciting input on issues related to health care access, accessing health care services and supports, and ensuring adequate provider payment rates to encourage provider access and quality within the Medicaid and CHIP programs. CMS plans to use input received to inform future rulemaking and other policies. The following presents draft Trinity Health responses to select RFI questions. Comments are due by April 18, 2022.

Draft Response by Question

Objective 1: Medicaid and CHIP reaches people who are eligible and who can benefit from such coverage. CMS is interested in identifying strategies to ensure that individuals eligible for Medicaid and CHIP are awareof coverage options and how to apply for and retain coverage. Eligible individuals should be able to apply, enroll in, and receive benefits in a timely and streamlined manner that promotes equitable coverage.

1. **What are the specific ways that CMS can support states in achieving timely eligibility determination and timely enrollment for both modified adjusted gross income (MAGI) and non-MAGI-based eligibilitydeterminations? In your response, consider both eligibility determinations and redeterminations for Medicaid and CHIP coverage, and enrollment in a managed care plan, when applicable.**

Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation, serving diverse communities that include more than 30 million people across 25 states. Driven by the belief that everyone should have access to health care coverage, Trinity Health views access to Medicaid coverage as key to making people-centered care possible. Trinity Health supports public policies that support better health, better care, and lower costs to ensure affordable, high quality, people-centered care for all. We appreciate efforts by CMS and states to support timely and accurate eligibility determinations and enrollment in the program, while also ensuring federal and state approaches do not result in unnecessary loss of coverage. To this end, we applaud CMS' decision to give states 12 months to initiate and 14 months to complete all renewals and other outstanding eligibility actions during the unwinding period following the end of the public health emergency (PHE). The 12-to-14-month window will allow for more time for states to perform determinations and enrollment, protect access to coverage for those who remain eligible and facilitate transfers to other programs when beneficiaries may no longer be eligible for Medicaid. We were pleased by the recent findings from a Kaiser Family Foundation survey[1] indicating that 41 states plan to take at least 9 months to complete all redeterminations, but we urge CMS to continue to encourage states to implement these actions in a way that guards against unnecessary loss of coverage. We also appreciate CMS' requirement that states start to process all new applications within 4 months of the end of the PHE as this will support determinations about and, potentially, enrollment in coverage for individuals who may otherwise not have a source of coverage. Finally, we applaud the support CMS has offered to states in the form of technical assistance and other guidance and urge it to continue to work with stakeholders to provide

[1] https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2022-findings-from-a-50-state-survey/

resources that clarify processes for states and other stakeholders, reduce burden during the unwinding period, and protect coverage.

We, however, urge CMS and state partners to take other actions to support new applications, renewals and enrollment including increasing publicity and marketing targeted towards helping current and potential enrollees understand upcoming changes in coverage and coverage options they may be eligible for (e.g., Medicaid, Marketplace, CHIP, Basic Health Program (BHP), and employer sponsored insurance). We also recommend that CMS and states consider the roles that other partners and stakeholders—such as navigators, social workers, and employers' human resources departments—could play in outreach, education and supporting enrollment.

We also urge CMS to encourage and support states' efforts to implement "no wrong door," integrated eligibility processes that streamline application, determinations, and enrollment. A recent study from Georgetown University and the Urban Institute found that "the 33 states that use the federal Marketplace platform HealthCare.gov and many SBMs do not have an integrated eligibility system that allows consumers to (1) receive a real-time determination of eligibility for either Medicaid coverage or Marketplace premium tax credits and (2) seamlessly enroll in the appropriate program" but instead rely on account transfer systems that then require consumers to newly apply for coverage.[2] Across our footprint, there are a number of states with approaches that support streamlined determinations and enrollment, which could serve as a model for CMS and other state partners. For example, New York has a single, integrated system that performs eligibility assessments for Medicaid, the Marketplace, CHIP, and the BHP.

To this end, it is also essential to support states in leveraging available data across systems and databases to process timely eligibility determinations and enrollment. Further, we support and encourage states to implement other policies such as express lane eligibility and other approaches that could support speedy eligibility determinations and enrollment. For example, CMS should encourage states to use successful approaches to presumptive eligibility—for example across Medicaid and SNAP or auto-enrollment without the need for an application. Additionally, where possible CMS and state partners could also consider how to integrate eligibility and enrollment capabilities into certain sites of care. For example, hospitals may be well positioned to reach patients who may be eligible and in need to immediate coverage, such as pregnant women delivering a baby.

Finally, as states restart their eligibility and enrollment processes, we strongly recommend that states prioritize processing applications for beneficiaries that are newly eligible for Medicaid, then address the backlog of renewals. We recommend this phased-in approach as it focuses on assessing eligibility for individuals who are eligible but may not currently be enrolled in coverage and allows for more time for outreach, education and communication with patients who may need to submit additional information to effectuate renewal or who may need to be transferred to and enrolled in another form of coverage.

3. In what ways can CMS <u>support states in addressing barriers to enrollment and retention of eligible individuals among different groups</u>, which include, but are not limited to: people living in urban or rural regions; people who are experiencing

[2] Preparing for the Biggest Coverage Event since the Affordable Care Act Perspectives from State Health Officials on the End of Medicaid's Continuous Coverage Requirement

homelessness; people who are from communities of color; people whose primary language is not English; people who identify as lesbian, gay, bisexual, transgender, queer, or those who have other sexual orientations or gender identities (LGBTQ+); peoplewith disabilities; and people with mental health or substance use disorders? Which activities would youprioritize first?

Trinity Health advocates for public policies that support better health, better care, and lower costs to ensure affordable, high quality, people-centered care for all. We believe that Medicaid is an important program in all communities and can be a driver of innovation and system transformation that expands and improves coverage for all populations, including those most vulnerable.

We believe that CMS can take a number of steps to support states in addressing barriers to enrollment and retention. As discussed in Question 1, policies such as express lane eligibility, presumptive eligibility, autoenrollment for certain beneficiaries can reduce barriers to eligibility determinations. Additionally, CMS should consider other approaches to reducing burden for beneficiaries, for example, by considering ways to support text-based enrollment and eligibility determinations through sharing pertinent information (such as a beneficiaries Medicaid enrollment number) and links to forms via text.

In terms of removing barriers to retention, Trinity Health supports actions by CMS to approve Section 1115 waivers and State Plan Amendments (SPAs) with policies that support continuous enrollment as this can reduce barriers to enrollment, retention and unnecessary loss of coverage or gaps in coverage. For example, a large number of the states we are in have gained approval of SPAs to offer 12-month continuous eligibility to children through 18 years of age and a growing number of our states have or will pursue Section 1115 waivers or SPAs with 12-month continuous eligibility postpartum.[3] We also support approval of waivers that expand access to needed services among vulnerable populations, such as waivers of the IMD exclusion.

We encourage CMS to continue to work with states to expand or test new policies via Section 1115 waivers that will further reduce barriers to enrollment and retention. For example, we recommend CMS approve waiver policies that support use of expanded workforce, such as community health workers or others that may support engagement with vulnerable populations eligible for or at risk of losing coverage. We also recommend CMS strongly consider approving newly proposed waivers that propose continuous eligibility policies that extend beyond 12 months, such as Oregon's waiver that propose continuous eligibility for children up to 6 years old and 2 years of continuous coverage for all beneficiaries over age 6.

Finally, we also urge CMS not to renew or approve new waivers that test restrictive enrollment or eligibility requirements (e.g., waivers of retroactive coverage) for people with disabilities, mental illness, substance use disorder, or other vulnerable populations. We applaud CMS' efforts to conclude waiver policies that could unnecessarily restrict access to coverage such as work and premium assistance requirements.

[3] Trinity Health states with 1115 Waivers include: IL, GA, and NJ. Trinity Health states that have enacted legislation to seek SPA or 1115 waiver include AL, CA, CT, MA, MD, MI, NC, OH, PA, SC, and TX.

Objective 2: Medicaid and CHIP beneficiaries experience consistent coverage. CMS is seeking input on strategies to ensure that beneficiaries are not inappropriately disenrolled and to minimize gaps in enrollment due to transitions between programs. These strategies are particularly important during and immediately afterthe COVID-19 Public Health Emergency (PHE) and can include opportunities that promote beneficiaries' awareness of requirements to renew their coverage as well as states' eligibility assessment processes, which can facilitate coverage continuity and smooth transitions between eligibility categories or programs (e.g., students eligible for school-based Medicaid services are assessed for Supplemental Security Income (SSI)/Medicaid eligibility at age 18, or youth formerly in foster care are assessed for other Medicaid eligibility after age 26).

1. **How should states monitor eligibility redeterminations, and what is needed to improve the process? How could CMS partner with states to identify possible improvements, such as leveraging managed care or enrollment broker organizations, state health insurance assistance programs, and marketplace navigators and assisters to ensure that beneficiary information is correct and that beneficiaries are enabled to respond to requests for information as a part of the eligibility redetermination process, when necessary? How could CMS encourage states to adopt existing policy options that improve beneficiary eligibility redeterminations and promote continuity of coverage, such as express lane eligibility and 12-month continuous eligibility for children?**

We believe there are a number of policies and approaches CMS can support states in considering or implementing that could improve eligibility redetermination processes.

Trinity Health supports states' efforts to leverage a range of partners—including navigators, Departments of Insurance, Marketplaces, managed care, enrollment brokers, and others— to support collection and verification of beneficiary information as this can reduce state administrative and beneficiary burden. As noted earlier (see Objective 1, Question 1), we also urge CMS to encourage and support states' efforts to implement "no wrong door," integrated eligibility processes that streamline application, determinations, and enrollment. Across our footprint, there are a number of states with approaches that support streamlined eligibility determinations and enrollment, which could serve as a model for CMS and other state partners. For example, New York has a single, integrated system that performs eligibility assessments for Medicaid, the Marketplace, CHIP, and the BHP. We also recommend CMS encourage and support states in leveraging available data across systems and databases to process timely eligibility determinations and enrollment. Finally, we urge states to implement policies such as express lane eligibility, presumptive eligibility, and auto enrollment, which could also support improved eligibility determination processes.

Trinity Health also encourages CMS to continue to work with states to propose and approve SPAs and Section 1115 waivers with policies that support continuous enrollment. For example, as noted earlier, we are supportive of current policies that enable 12-month continuous enrollment for a range of populations and support testing new policies, where appropriate, that could expand continuous eligibility further. For example, Oregon currently has a waiver pending review that requests multi-year continuous enrollment—for children up to age 6 and 2-year continuous enrollment for beneficiaries over age 6.

2. How should CMS consider setting standards for how states communicate with beneficiaries at-risk of disenrollment and intervene prior to a gap in coverage? For example, how should CMS consider setting standards for how often a state communicates with beneficiaries and what modes of communication they use? Are there specific resources that CMS can provide states to harness their data to identify eligible beneficiaries at-risk of disenrollment or of coverage gaps?

Trinity Health recommends CMS consider several methods as it works to develop standards for approaches states could use to communicate with beneficiaries at risk of disenrollment. As discussed earlier (see response to Objective 1, Question 3), we encourage CMS to consider approaches to reducing burden for beneficiaries, for example, by considering ways to support text-based enrollment and eligibility determinations through sharing pertinent information, such as a beneficiary's Medicaid enrollment number, and links to forms via text.

We also recommend CMS consider how to rely on critical members of a patient's care team to support communication, education, and potentially enrollment, among beneficiaries at risk of disenrollment. Trinity Health believes that delivery of high-quality, people-centered care that reaches a wide range of patients requires use of an innovative workforce and innovative approaches to outreach and engagement with patients. To this end, our health system relies on many well-trained health care professionals to deliver high-quality physical and behavioral health care and long-term services and support (LTSS), ensure access to community-based services, meaningfully coordinate care, address social determinants of health and advance health equity. Critical to our workforce are community health workers and social workers. These members of a provider care team are connected to the broader communities in which they serve and could be leveraged to support outreach, education, and enrollment processes, especially among hard to reach or other beneficiaries at risk of disenrollment. We recommend that CMS and states consider how best to leverage these essential members of the care team—who already serve as a key point of contact for many beneficiaries. This will require education and other communication to these essential providers about plans and timing for eligibility determinations and disenrollment as well as to how to support patients in re-enrolling or identifying and enrolling in other affordable coverage options.

4. What actions could CMS take to promote continuity of coverage for beneficiaries transitioning between Medicaid, CHIP, and other insurance affordability programs; between different types of Medicaid and CHIP services/benefits packages; or to a dual Medicaid-Medicare eligibility status? For example, how can CMS promote coverage continuity for beneficiaries moving between eligibility groups (e.g., a child receiving Early and Periodic Screening, Diagnosis, and Treatment [EPSDT] qualified supports who transitions to other Medicaid services such as home and community based services [HCBS] at age 21, etc.); between programs (Medicaid, CHIP, Basic Health Program, Medicare, and the Marketplace); or across state boundaries? Which of these actions would you prioritize first?

As discussed earlier (see Objective 1, Question 1), Trinity Health urges CMS to encourage and support states' efforts to implement "no wrong door," integrated eligibility processes that streamline applications, determinations, and enrollment as this will help reduce duplication of efforts and burden across state agencies and beneficiaries. Across our footprint, there are a number of states with approaches that support streamlined determinations and enrollment, which could serve as a model for CMS and other state partners. For example, New York has a single, integrated

system that performs eligibility assessments for Medicaid, the Marketplace, CHIP, and the BHP.

Beyond streamlining eligibility and enrollment systems across multiple programs, states can also leverage existing members of care teams and resources to support the smooth transition of beneficiaries between different coverage options. Specifically, Trinity Health recommends CMS work with states to leverage partners who may serve as a main point of contact and resource to beneficiaries such as navigators, social workers, and care coordinators working for managed care plans, among others. However, education of navigators and other partners will be essential to support smooth transitions, especially during the unwinding period following the PHE when millions of current enrollees may lose Medicaid eligibility. We appreciate CMS' efforts to provide guidance and technical assistance to states and their managed care partners as well as its continued efforts to help stakeholders prepare for the unwinding of the continuous coverage requirements.

Further, it is critical that CMS and its state partners consider and, to the extent possible, ease other challenges beneficiaries may experience as they transition between coverage options. For example, beneficiaries switching from Medicaid or CHIP to a marketplace plan, may no longer have access to care management services. It will be important to educate those supporting these transitions—such as navigators, social workers, representative from health plans—and the beneficiaries themselves about differences in coverage.

While we understand the original intention of the BHP program, based on our experience, availability of a BHP appears to generate confusion among beneficiaries exploring their coverage options and has the potential to stifle competition in the marketplace. As a result, we recommend states and CMS work to pursue other policies instead of a BHP, such as continuous enrollment policies permitted under SPA and section 1115 waivers.

Objective 3: Whether care is delivered through fee-for-service or managed care, Medicaid and CHIP beneficiaries have access to timely, high-quality, and appropriate care in all payment systems, and this carewill be aligned with the beneficiary's needs as a whole person. CMS is seeking feedback on how to establish minimum standards or federal "floors" for equitable and timely access to providers and services, such as targets for the number of days it takes to access services. These standards or "floors" would help address differences in how access is defined, regulated, and monitored across delivery systems, value-based payment arrangements, provider type (e.g., behavioral health, pediatric subspecialties, dental, etc.), geography (e.g., byspecific state regions and rural versus urban), language needs, and cultural practices.

1. **What would be the most important areas to focus on if CMS develops <u>minimum standards</u> for Medicaid and CHIP programs related to access to services? For example, should the areas of focus be at the national level, the state level, or both? How should the standards vary by delivery system, value- based payment arrangements, geography (e.g., sub-state regions and urban/rural/frontier areas), program eligibility (e.g., dual eligibility in Medicaid and Medicare), and provider types or specialties?**

Trinity Health recommends that CMS establish access standards for medical services, behavioral health services, and LTSS given these are critical elements for the delivery of whole-person care. We also recommend CMS consider standards for access to services that support health-related social needs as these are also essential to supporting better health. Further, we urge CMS to establish national minimum standards as this will create a baseline that will help to assure

consistent minimum requirements for access to services regardless of where beneficiaries live. CMS could consider incorporating components of the county classification system used for Medicare Advantage (MA), which accounts for differences in population density. We also recommend that access standards be as consistent as possible across managed care and fee for services (FFS) and, when appropriate, within value-based payment arrangements. Consistency in standards across states and delivery systems can help reduce burden on providers, payers and other stakeholders that play a role in multiple states' health care systems

We also urge CMS to consider how to align and make consistent network adequacy and access standards across qualified health plans and Medicaid—to the extent feasible—given the churn that occurs between populations enrolled in both types of coverage.

In terms of specific measures of access, Trinity Health believes that wait time is a more appropriate measure of access as compared to patient-to-provider ratios as the later does not reflect whether or not a provider is accepting new patients. Access to telemedicine may also be an appropriate factor to consider, especially with respect to beneficiaries in certain regions or for certain provider types.

Finally, as CMS considers establishing standards related to access to services, we recommend it consider access to services and programs that are currently a state option. For example, PACE is an optional program that states may choose to offer. We strongly encourage CMS to provide guidance and/or incentives to states to implement this program as it would increase access to needed care for vulnerable beneficiaries. Further, CMS could work with Congress to consider establishing PACE as a mandatory benefit.

2. **How could CMS <u>monitor states' performance against those minimum standards</u>? For example, what should be considered in standardized reporting to CMS? How should CMS consider issuing compliance actions to states that do not meet the thresholds, using those standards as benchmarks for quality improvement activities, or recommending those standards to be used in grievance processes for beneficiaries who have difficulty accessing services? In what other ways should CMS consider using those standards? Which of these ways would you prioritize as most important?**

As CMS works to monitor states' performance against minimum access standards, we urge CMS to establish national minimum standards for the Medicaid program in Medicaid managed care and in FFS. We also strongly recommend CMS work to align and make consistent network adequacy and access standards across qualified health plans and Medicaid—to the extent feasible. Consistency across states and programs will support uniformity in access across beneficiaries and reduce CMS and other stakeholders' burden. Regarding standardized reporting, a similar approach to that used in MA could be considered. This could entail submission of data similar to Health Service Delivery (HSD) tables before the beginning of the calendar year, which would show that the network meets minimum standards related to geographic access (i.e., time and distance). During the calendar year, self-reporting, third-party audits, or regulatory audits would ensure wait times are within reasonable standards. In terms of compliance actions that CMS should impose on states, we recommend CMS give any state deemed not in compliance with minimum standards the period of time between the determination and the next quarterly audit to meet minimum standards or face penalties.

3. **How could CMS consider the concepts of whole person care[1] or care coordination across physical health, behavioral health, long-term services and supports (LTSS), and health-related social needs when establishing minimum standards for access to services? For example, how can CMS and its partners enhance parity compliance within Medicaid for the provision of behavioral health services, consistent with the Mental Health Parity and Addiction Equity Act? How can CMS support states in providing access to care for pregnant and postpartum women with behavioral health conditions and/or substance use disorders? What are other ways that CMS can promote whole person care and care coordination?**

Trinity Health is committed to providing people-centered care for all. We believe that access to physical, behavioral health, LTSS, and services that support health-related social needs is essential to supporting better health, better care and lower costs. As CMS works to establish minimum access standards that support whole person care, we urge it consider steps to promote access to this full range of services.

Specifically related to social determinants of health, Trinity Health believes there are a number of approaches CMS and states can take to support access to supportive services. Based on our experience, Medicaid beneficiaries may be eligible for additional programs including SNAP or TANF, however, they may face barriers to enrollment into these programs or services. To help address this barrier, we recommend that CMS encourage and support state efforts to develop common applications, streamlined eligibility systems, and educate and train navigators to ensure these tools are available to support access to additional services. For example, Indiana has implemented a common application that is used for assessing eligibility for and facilitating enrollment into Medicaid, SNAP, TANF and that also includes a screener for social determinant of health needs. We have seen other promising models utilized across our footprint, including the use of enhanced care coordinators in California. We believe that access to health insurance coverage as well as other supports to address health-related social needs is essential to improve health and outcomes and deliver whole person care. In addition, population-based payment models are integral in providing whole-person, coordinated care. We urge CMS to work with CMMI and states to design and incentivize sustainable payment models that move away from fee-for-service and instead focus on patient-centric care delivery and coordination. To this end, as noted above, we strongly recommend CMS work with states, and potentially with the Congress, to expand access to the PACE program. We also recommend CMS work with states to advance fully integrated programs for dual eligible such as FIDE D-SNPs or the Senior Care Options program in Massachusetts.

5. **What are specific ways that CMS can support states to increase and diversify the pool of available providers for Medicaid and CHIP (e.g., through encouragement of service delivery via telehealth, encouraging states to explore cross-state licensure of providers, enabling family members to be paid for providing caregiving services, supporting the effective implementation of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits, implementing multi-payer value-based purchasing initiatives, etc.)? Which of these ways is the most important?**

Trinity Health appreciates and supports CMS' acknowledgement of the need to increase and diversify the pool of available providers. We support efforts to increase access to and expand the supply of providers that beneficiaries are able to access. As part of these efforts, we recommend CMS and states ensure coverage includes reimbursements for services provided by community

health workers, peer support specialists and other members of a patient's care team. While there are no national accrediting bodies for community health workers and peer support specialists, some states (e.g., ID, MI, OH, OR) have accrediting boards, which supports the ability of these providers to bill. In addition, CMS and states should work to ensure coverage of services and promote adoption of state laws and regulations that would expand the types of care team members that can participate and be reimbursed for providing care.

We urge CMS and state partners to consider making permanent, or at least extending, flexibilities permitted during the PHE, which relaxed state licensure requirements and permitted providers to deliver care across state lines. This would support states' abilities to address workforce challenges and support beneficiary access to key providers regardless of whether they are located in the same state. Second, we recommend CMS and states consider policies to support access to and reimbursement for remote patient monitoring (RPM) and telehealth, including audio-only visits, which are critical in low-income communities or communities with limited broadband access. We also recommend CMS and states consider allowing reimbursement for certain text-based services, including a crisis text line. Extending temporary flexibilities or implementing permanent policies that remove certain state licensure requirements and expand reimbursement for telehealth and RPM can help meet patients where they are and also help states address workforce issues.

Objective 4: CMS has data available to measure, monitor, and support improvement efforts related to access to services (i.e., potential access; realized access; and beneficiary experience with care across states, delivery systems, and populations). CMS is interested in feedback about what new data sources, existing datasources (including Transformed Medicaid Statistical Information System [T-MSIS], Medicaid and CHIP Core Sets, and home and community based services (HCBS) measure set), and additional analyses could be used to meaningfully monitor and encourage equitable access within Medicaid and CHIP programs.

4. **In what ways can CMS promote a more standardized effort to <u>monitor access in long-term services and supports (LTSS), including HCBS, programs?</u> For example, how could CMS leverage the draft HCBSmeasure set, grievances and appeals, or states' comparisons of approved Person-Centered Service Plans to encounter or billing data in managed care or fee-for-service to ensure appropriate services are being received? Which activities would you prioritize first?**

Trinity Health believes that access to LTSS, including home and community-based services (HCBS) and other programs, such as PACE is critical for Medicaid beneficiaries. As such, Trinity Health urges CMS to consider supporting expanded access to services and programs that are currently a state option. For example, PACE is an optional program states can choose to offer. We strongly encourage CMS to work with states to implement this program as it would increase access to needed care for vulnerable beneficiaries.

Objective 5: Payment rates in Medicaid and CHIP are sufficient to enlist and retain enough providers so that services are accessible. Section 1902(a)(30)(A) of the Social Security Act (the "Act") requires that Medicaid state plans "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extentthat such care and services are available to the general population in the geographic area." Section 1932 of theAct includes additional provisions related to managed care. Section 2101(a) of the Act requires that child health assistance be provided by States "in an effective and efficient manner…." CMS is interested in leveragingexisting and new access standards to assure Medicaid and CHIP payments are sufficient to enlist enough providers to ensure that beneficiaries have adequate access to services that is comparable to the general population within the same geographic area and comparable across Medicaid and CHIP beneficiary groups, delivery systems, and programs. CMS also wants to address provider types with historically low participation rates in Medicaid and CHIP programs (e.g., behavioral health, dental, etc.). In addition, CMS is interested in non-financial policies that could help reduce provider burden and promote provider participation.

1. **What are the opportunities for CMS to <u>align approaches and set minimum standards for payment regulation and compliance</u> across Medicaid and CHIP delivery systems (e.g., fee-for-service and managed care) and across services/benefits to ensure beneficiaries have access to services that is as similar as possible across beneficiary groups, delivery systems, and programs? Which activities would you prioritize first?**

Given current health care workforce shortages and conflicting demands on the health care system from the increased size of the Medicaid population and the PHE, it is important for CMS and states to assess various strategies to ensure beneficiaries have access to providers and services, including services that support health-related social needs as these are also essential to supporting better health. Importantly, we believe that CMS should consider ways to incentivize providers to accept Medicaid patients, which could include encouraging states to implement minimum payment rates that adequately cover the cost of care for the annual physical, immunizations, screenings, and other key services. This would also help ensure beneficiaries have the opportunity to identify health conditions and needs sooner.

Further, Trinity Health is committed to care delivery that holds providers accountable for the health of the people and communities we serve, and that advances health equity across populations. As part of this commitment, we support implementation of value-based care models that tie payment to improved outcomes, quality, and population health. We are currently participating in value-based payment (VBP) arrangements across Medicare, Medicaid and with commercial payers.

Specifically, Trinity Health has 17 Clinically Integrated Networks (CINs) that are accountable for approximately 1.5 million lives across the country through alternative payment models. Our health care system participates in 14 markets with Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs), which includes eleven markets partnering in one national MSSP Enhanced Track ACO, Trinity Health Integrated Care. Two of the 14 markets also participate in CPC+. In addition, we have 33 hospitals participating in the Bundled Payments for Care Improvement Advanced (BPCIA) initiative, and three hospitals in the Comprehensive Care for Joint

Replacement (CJR) program. Our work—and experience in value-based contracting—also extends beyond Medicare as illustrated by our participation in 123 non-CMS APM contracts.

We recommend that CMS continue to work with states to implement VBP models and arrangements that support population health and accountability for care. To this end, we urge CMS to continue to approve Section 1115 waivers or work with the Innovation Center to test models that aim to improve outcomes, quality, and control costs as these programs allow us to integrate care through more innovative approaches, particularly across medical and behavioral health conditions. We are working with states across out footprint, including New York, Massachusetts and Idaho, to implement VBP models approved as part of their Section 1115 waivers and would welcome the opportunity to offer insights to CMS.

Additionally, based on our experience, managed care plans have been less likely to develop contracts with providers under VBPs for total cost of care and clinical accountability. We urge CMS to work to incentivize Medicaid MCOs to implement models that allow providers to share in risk and reward. Similarly, we recommend CMS consider ways to clarify and share best practices or promising approaches across states and MCOs demonstrating how MCOs and providers may share risk for managing total cost of care. We also recommend that CMS establish minimum MLR requirements for managed care plans across all states and urge states with MLR requirements to enforce them.

2. **Medicare payment rates are readily available for states and CMS to compare to Medicaid payment rates, but fee-for-service Medicare rates do not typically include many services available to some Medicaid and CHIP beneficiaries, including, but not limited to, most dental care, long-term nursing home care, and home and community-based services (HCBS). What data sources, methods, or benchmarks might CMS consider to assess the sufficiency of rates for services which are not generally covered by Medicare or otherwise not appropriate for comparisons with Medicare?**

We recommend CMS look at the actual cost of providing long stay nursing home care and create a floor for payment. We also would ask that CMS look into ways to incentivize or require states to update Medicaid payment rates on a regular basis – part of the issue that is that in some states, these reimbursement rates have not been updated for years and are not aligned with the current economic environment.

For both mandatory benefits like nursing home care and home health and HCBS benefits like adult day, PACE, transportation, personal care, and others, we ask that the cost of workforce be built into new rates and adjusted with regularity.

5. **Some research suggests that, in addition to payment levels, administrative burdens that affect payment, such as claims denials and provider enrollment/credentialing, can discourage provider acceptance of Medicaid beneficiaries.[2] What actions could CMS take to encourage states to <u>reduce unnecessary administrative burdens that discourage provider participation in Medicaid and CHIP</u> while balancing the need for program integrity? Which actions would you prioritize first? Are there lessons that CMS and states can learn from changes in provider enrollment processes stemming from the COVID-19 Public Health Emergency?**

As discussed previously (see Objective 5, Question 1), Trinity Health recommends that CMS establish standardized administrative approaches related to MLR requirements, where possible, for plans across states. At a minimum, CMS should urge states to enforce MLR requirements where they exist.

To further reduce unnecessary administrative burden, we recommend CMS work to minimize unnecessary reporting requirements. As discussed earlier (see Objective 3, Question 1), we also recommend CMS work to standardize quality measures, reporting and other requirements across managed care and FFS.