



October 27, 2022

Ami Bera, M.D.
Member of Congress

Larry Bucshon, M.D.
Member of Congress

Kim Schrier, M.D.
Member of Congress

Michael Burgess, M.D.
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Earl Blumenauer
Member of Congress

Brad Wenstrup, D.P.M.
Member of Congress

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Member of Congress

Mariannette Miller-Meeks, M.D.
Member of Congress

Re: MACRA Request for Information

Submitted electronically via to macra.rfi@mail.house.gov

Dear Members,

Trinity Health appreciates the opportunity to comment on the Medicare Access and CHIP Reauthorization Act (MACRA) request for information. Our comments and recommendations reflect a strong interest in public policies that support better health, better care and lower costs to ensure affordable, high quality, and people-centered care for all.

Trinity Health is one of the largest not-for-profit, Catholic health care systems in the nation. It is a family of 123,000 colleagues and more than 26,000 physicians and clinicians caring for diverse communities across 26 states. Nationally recognized for care and experience, the Trinity Health system includes 88 hospitals, 135 continuing care locations, the second largest PACE program in the country, 136 urgent care locations and many other health and well-being services. Trinity Health has 15 medical groups with 1,324 primary care providers and 4,193 specialty care providers. Based in Livonia, Michigan, its annual operating revenue is \$21.5 billion with \$1.4 billion returned to its communities in the form of charity care and other community benefit programs.

Trinity Health has 17 Clinically Integrated Networks (CINs) that are accountable for approximately 2 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. All of these markets participated in the “enhanced track”, which qualifies as an advanced alternative payment model (AAPM). Two of the 14 markets also participate in CPC+. In addition, we have had 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.

In addition, the Medicare Advantage (MA) plan managed by Trinity Health–MediGold–plays a vital role in our integrated delivery network and provides key care coordination for our patients. MediGold is a high-quality, consumer-centric MA plan; the Ohio HMO plan received a high 4.5 STAR rating from CMS. Over fifty-percent (50%) of MediGold contracts are value-based agreements. MediGold utilizes industry standard and transparent guidelines for many decisions on precertification and other authorization approval processes, removing ambiguity of guidelines for providers. At MediGold, our utilization management nurses work with members and providers to coordinate care for beneficiaries identifying the beneficiary needs and working with providers to provide the needed care.

Inadequacy of Medicare Payment

Trinity Health urges Congress to encourage the Medicare Payment Advisory Commission (MedPAC) to review the adequacy of Medicare payment, the timing of payment updates, and underlying data sources used to calculate Medicare payment. It is well documented that Medicare does not cover the full cost of caring for beneficiaries; most recent findings are that hospitals received payment of 84 cents for every dollar spent by hospitals caring for Medicare patients in 2020.¹

The hospital market basket is an input price index that measures the average percentage change in the price of goods and services hospitals purchase to provide inpatient care. As a fixed-weight index, the hospital market basket measures changes in prices over time of the same mix of goods and services purchased during a base period. As a result, any changes in the mix of goods and services are not measured annually. CMS rebases the hospital market basket every four years. The current market basket, which was rebased for FY 2022, reflects hospital costs from Medicare cost reports that began on or after October 1, 2017 and before October 1, 2018. CMS updates the market basket annually by forecasting costs using available historical data and there is a data lag between what hospitals and providers experience real time and the payment updates promulgated through the Medicare payment rules each year. When historical data is no longer a good predictor of future changes, the market basket becomes inadequate.

Trinity Health recommends that MedPAC and the Centers for Medicare and Medicaid Services (CMS) explore ways that the CMS Office of the Actuary (OACT) can adjust the market basket methodology to reflect real-time service utilization and expenses to more fairly reimburse providers, including identifying alternative data sources (such as hospital data) to determine payment during times of crisis such as the COVID-19 PHE and inflation.

One key example of where the market basket has been inadequate are the inputs for hospital labor costs. Trinity Health has experienced a 12% increase in labor costs compared to pre-pandemic levels due to the rates for contract labor and premium labor rates we must pay in order to have staff to care for patients in our hospitals. In addition, we have raised pay rates for full and part-time nurses who are employed well above historical averages and these costs will continue to rise as the staffing shortage continues into the foreseeable future. CMS updates labor costs using data from the U.S. Bureau of Labor Statistics' (BLS) Employment Cost Index (ECI). The ECI survey of hospital employment costs only includes employed hospital workers, not contracted employees. Therefore, the payment updates promulgated since the COVID-19 pandemic began have not accounted for the surge in labor costs due to contract labor. Contract labor as a percentage of total hours and contract labor as a percentage of total labor expenses both increased five-fold between 2019 and 2020. As of March 2022, the

¹ Factsheet: Underpayment by Medicare and Medicaid, The American Hospital Association, February 2022. <https://www.aha.org/fact-sheets/2020-01-07-fact-sheet-underpayment-medicare-and-medicaid>.

median wage rate for contract nurses was four times higher than the wage rate for employed nurses.² **Had there been the mechanism for CMS OACT to factor in the significant contract labor costs, reimbursement to hospitals would have better reflected the true workforce costs of responding to the pandemic.**

While the RFI is focused on MACRA and Medicare, **Trinity Health also notes that inadequate Medicaid reimbursement as well as inadequate commercial insurer reimbursement and abuse of reimbursement utilization programs, such as prior authorization, make it challenging to provide care to our communities.** Hospitals' expenses are significantly elevated from pre-pandemic levels and expenses are predicted to increase throughout the rest of 2022, leading to an increase of nearly \$135 billion over 2021³. Hospitals have faced a profound financial toll—Trinity Health's cost per case has increased 14%, including 20% increase in drug costs, and 9% increase in implant costs over pre-pandemic amounts. This is in addition to the 12% increase in labor costs. Further, hospital patients are sicker and more medically complex, even non-COVID-19 patients, due to delayed or avoided care during the pandemic and unlike other industries, hospitals have limited pricing flexibility to offset increased costs of care. These financial pressures significantly impact our patients and the communities we serve. Across our footprint, services have been forced offline with approximately 12% of our beds, 5% of our operating rooms, and 13% of our emergency department operating below capacity due to staffing. Some of our facilities are experiencing constrained capacity at even higher levels, with 20-25% of beds, 50% of operating rooms and diagnostic services offline. In addition, backlogs are growing for surgery, imaging and diagnostic services and the rate of patients who leave the emergency department before being seen has doubled from pre-pandemic levels.

Trinity Health applauds the House for the bipartisan introduction of H.R. 8800, Supporting Medicare Providers Act, that would mitigate Medicare payment cuts scheduled for January 1, 2023. This bill is an important first step in adding stability and predictability for physician practices and protecting patient access to physician care. Trinity Health also urges Congress to prevent the 4% PAYGO cuts to Medicare triggered by the American Rescue Plan Act of 2021 from taking effect.

Medicare Access and CHIP Reauthorization Act (MACRA)

Trinity Health is a leading health system implementing value-based care, with nearly \$11 billion in cost of care accountability for approximately 2 million patients. We're proud of what we've done to demonstrate what a health system can do when partnering with clinicians to create better health outcomes at a lower cost for patients and the members we serve. Since 2015, Trinity Health's family of ACO programs have generated over \$300M in savings for CMS through both MSSP as well as the Next Generation ACO program.

Trinity Health strongly believes AAPMs are effective at improving quality of care for patients while lowering costs. We urge Congress to work with CMS to develop total cost of care opportunities for providers like us who are able capable of delivering quality care and outcomes while bending the cost curve.

We appreciate the goal of MACRA to shift the focus of care for Medicare beneficiaries from volume to value. The data suggests that we have not achieved this goal. We have seen the positive outcomes ACOs in AAPMs have offered; however, the growth rate of Medicare beneficiaries in AAPMs has not had a statistically significant

² Kaufman Hall, The Financial Effects of Hospital Workforce Dislocation, May 2022.

³ Kaufman Hall, The Current State of Hospital Finances: Fall 2022 Update, https://www.kaufmanhall.com/sites/default/files/2022-09/KH-Hospital_Finances_Report-Fall2022.pdf.

change spanning back to before when MACRA was implemented to this point in time. To be successful in the goals of the policy, growth needs to be fueled, which it seems MACRA has not achieved. From 2012 to 2015 we saw a growth rate of about 32% in MSSP assigned beneficiaries. From 2016 to 2022 we have seen a 6% growth rate in beneficiaries.⁴ We have moved from 3.2M to 11.0M beneficiaries over that total time span which is not insignificant in total beneficiaries, and removing the 5% AAPM bonus will slow growth even further. From the proposed CY2023 Physician Fee Schedule (PFS), we can see that CMS estimates that as many as 100,000 clinicians currently participating in value-based models of care may stop doing so if Congress does not extend the Medicare incentives, meaning care coordination and services meant to address patients' social needs could go away.

The Merit-based Incentive Program (MIPs) has struggled to meet the goals of rewarding providers for the shift to value. The maximum adjustment for MIPs providers is 9%. Due to budget neutrality, the scaling factor applied to providers has never allowed physicians to come close to this level of adjustment. Additionally, small practices that are still required to report MIPs when meeting the volume thresholds may struggle to invest in the infrastructure needed to support their reporting. This leaves them with an option of consolidation and losing their independence or reporting poorly or not at all and receiving potentially the maximum negative adjustment. **Methods need to be put in place to allow these practices to retain their independence while reporting successfully with the resources they have.** For those practices that have the option of reporting, but not the requirement, the maximum payment adjustment does not seem worth the investment in reporting vs taking the neutral adjustment provided by opting out. This does not drive moving these providers to report MIPs. Sites however could join a network of independent providers under an AAPM and be exempt from MIPs and receive an AAPM bonus of 5%, if extended, which incentivizes them two-fold to manage care under AAPMs.

The QPP should continue to offer the web interface reporting option for AAPM and traditional MIPs quality reporting component and do away with the all-payer component of the eCQM option. Many large ACOs / provider organizations operate on a varied number of electronic medical records (EMRs) in which the electronic clinical quality measures (eCQM) information is produced from. Trinity Integrated care, our national ACO which has been in place since 2017 and today serves around 135,000 beneficiaries operates on 50+ EMRs and within those different versions spanning hundreds of non-alike interfaces. To report compliantly under current proposals, it falls on the organizations to aggregate and dedupe all the reporting information to accurately report. To meet the timeline of 2025, many organizations face a steep financial challenge of partnering with a vendor representative to assist in reporting this information accurately.

We appreciate CMS effort to create a less burdensome quality reporting mechanism in the CY23 Physician Fee Schedule proposed regulation, but this proposal creates more burden on setting up the infrastructure to be able to report accurately. Additionally, the all-payer requirement presents data collection challenges and concerns of exposure of protected health information (PHI) for which an ACO entity may have no contractual relationship for a specific patient population. Organizations and clinicians are concerned with sending patient information to an entity reporting ACO quality when the only contractual relationship to the entity is through the MSSP ACO. We support providing lower costs and better quality across patient populations but understand that an ACO entity may not be ultimately responsible for patient populations in which there is no contractual relationship.

⁴ Center for Medicare and Medicaid Services, Shared Savings Program Fast Facts, <https://www.cms.gov/files/document/2022-shared-savings-program-fast-facts.pdf>

Congress should extend the 5% Advanced Alternative Payment Model (AAPM) bonus for clinicians participating in the AAPMs and eliminate qualifying thresholds. As we have noted above, Trinity Health strongly believes AAPMs work to improve the quality of care provided to patients and lower costs. The direct incentive has been a main focal point for encouraging clinicians to partner with our AAPMs across Trinity Health. If the policy objective is to retain and grow provider participation in AAPMs, allowing this bonus to expire would be in direct objection to the policy.

Studies show that year over year, ACOs in two-sided risk models were more likely to achieve savings.⁵ A major incentive to moving to two-sided risk is being able to qualify for the AAPM bonus. Ending the bonus means less reward for the risk, and many ACOs have already indicated that without the 5% bonus they would reevaluate the risk-reward calculation. Given that the proposed PFS rule has a much slower pathway to full risk, the 5% bonus takes on even more importance in that calculation.

The conversion factor in the proposed PFS rule creates less of an incentive in the AAPM than it does to report and achieve a maximum MIPS adjustment (based on historical adjustments) leading physicians to question the incentive of participating in these models. In extending the 5% incentive, Congress should also consider evaluating the timing of these payments. The time from electing to participate in a model to receiving the incentive spans almost 3 years. A model needs to be in place for providers to receive an incentive more closely tied to the work for the specific performance period. In extending this bonus congress should consider doing away with payment / patient count QP thresholds for providers that practice in an AAPM. These thresholds are expected to increase to levels that many value driven clinicians achieving the policy objectives of lowering cost, and bettering quality would not meet, excluding them from the bonus and MIPS exclusion. In the MSSP model many practices have large multispecialty TINs that have specialist providers that bring down the patient count ratio. This leaves organizations with the decision of restructuring their TINs at risk of missing the threshold, and organizations having providers feeling less incentivized to participate and perform in AAPMs.

Specialty specific value-based models should also be considered. While MIPS tries to create a value-based program, it is largely centered around primary care physicians. CMS should consider adoption of more specialty-specific value-based models that more closely tie to the aims of those specific specialties. The complexity of reporting measures across different specialties that relevantly tie to the clinician's expertise is not clear. More models that incentivize and tie cost and outcomes to the work the specialist provider produces would help engage important specialist in achieving the goal of value-based care---improved care for patients while lowering the cost of care.

In summary we feel we the following items would help us to achieve policy goals established by MACRA

- Extension of the 5% AAPM bonus
- Elimination of the QP threshold required to qualify for the AAPM bonus
- Model focus on specialty specific providers
- Extension of web interface reporting / elimination of all payer eCQM reporting

⁵ Health Affairs, Performance Results of the Medicare Shared Savings Program in 2021: Continued Uncertainty with Positive Movement, October 2022. [Performance Results Of The Medicare Shared Savings Program In 2021: Continued Uncertainty With Positive Movement | Health Affairs](#)

Medicare Advantage (MA)

Many MA plans (and non-MA commercial insurers) unfairly use utilization management techniques to delay critical care. This includes prior authorization, certifications, and medical necessity reviews that lead to unnecessary claim denials. A recent U.S. Department of Health and Human Services Office of Inspector General report concluded that many MA plans have a pattern of denying prior authorization and payment requests that meet Medicare coverage and billing rules. The report also affirms the findings of the CMS annual audits of MA plans and highlights “widespread and persistent problems related to inappropriate denials of services and payment.”¹

On prior authorization, there is significant industry variation in terms of when prior authorization is necessary, submission processes, standard treatments, documentation requirements and definitions of medically necessary care. As a result, patients may wait days for medically necessary procedures, treatments or prescriptions. This can not only impact care, but may also create anxiety for the patient while burdening the clinical team and their staff.

On claims denials, from July 1, 2021 to April 30, 2022 Managed Care MA Plans had denied over \$1.12 billion on 147,000 claims across Trinity Health facilities, compared to traditional Medicare denials of \$0.38 billion on 112,000 claims, despite gross revenue being just about equal between the two. This high rate of denials both affects patients and causes significant administrative burden. In Trinity Health’s experience:

- Administrative burden associated with commercial plan denials costs Trinity Health \$10 million per month.
- 8 to 10% of Trinity Health's total hospital encounters are routinely denied on first submission.
- A requirement to submit excessive documentation is the top reason for payment denial. However, documentation denials are almost always eventually approved.
- Clinical denials require an arduous appeals process that often includes peer-to-peer interactions with clinical staff, with an eventual approval 55 to 65% of the time.

Trinity Health has experienced the following excessive utilization management and medical necessity review practices that delay care, create uncertainty for patients, and cause unnecessary administrative burden:

- Excessive, unreasonable requests for documentation (insurers are not always clear or transparent about what documentation is required when initial claims are filed).
- Failure to provide prior authorization when necessary to prevent harm and care for patients, leading to delays in care.
- Observation status and short-stay denials even when clinical indicators meet standards for care.
- Reimbursement for sepsis that is inconsistent with standard coding and diagnosis so as to not reimburse for early-stage care.
- Site of service exclusions for coverage of emergency care and diagnostic testing.
- Inaccurate enrollment files based on payer error.
- Utilization management and implementation of new policies to delay payment.

Inappropriate prior authorization and payment denials restrict or delay patient access to care and contribute to health care provider burn out. Further, such utilization and payment tactics drive our nation's health care costs up and add burden to the health care system. **We urge Congress to take steps to reduce the impact of improper utilization management techniques by both MA and non-MA plans, while still ensuring program integrity. Trinity Health applauds the House for passing the Improving Senior’s Timely Access to Care Act (H.R. 3173), as it is a great first step.**

We know MA plans can do better because as stated earlier, Trinity Health's MA plan, MediGold, utilizes Milliman Care Guidelines for many decisions on precertification and other authorization approval processes, removing ambiguity of guidelines for providers. The way MediGold operates demonstrates that the aggressive tactics deployed by some MA plans is not necessary for success.

We also recommend that CMS take steps to incentivize MA plans to move more aggressively toward value-based care. Value-based care lowers rising health care costs--ensuring affordability for all—connects clinical care to social care needs, and has proven to improve health outcomes. **MA plans and other commercial payers must expedite their shift to payment models that transfer total cost of care responsibility to providers and reward providers fairly for taking responsibility in new ways for a patient's overall health.** When providers take responsibility for the total cost of care, there is limited need for utilization management by the health plan as the provider is at risk for assuring appropriate access and management of care.

Conclusion

We appreciate the opportunity to comment on the RFI. If you have any questions on our comments or would like to talk about any of these topics in more detail, please feel free to contact me at jennifer.nading@trinity-health.org.

Sincerely,

/s/

Jennifer Nading
Director, Medicare and Medicaid Policy and Regulatory Affairs
Trinity Health