Trinity Health

August 31, 2022

Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-4203-NC; Medicare Program; Request for Information on Medicare

Submitted electronically via http://www.regulations.gov

Dear Administrator Brooks-LaSure,

Trinity Health appreciates the opportunity to comment on the Medicare Advantage (MA) questions posed in CMS-4203-NC. Our comments and recommendations to the Centers for Medicare and Medicaid Services (CMS) 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 115,000 colleagues and nearly 26,000 physicians and clinicians caring for diverse communities across 25 states. Nationally recognized for care and experience, the Trinity Health system includes 88 hospitals, 131 continuing care locations, the second largest PACE program in the country, 125 urgent care locations and many other health and well-being services. Based in Livonia, Michigan, its annual operating revenue is $20.2 billion with $1.2 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. 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 MA plan managed by Trinity Health–MediGold–plays a vital role in our integrated delivery network and provides key care coordination for our patients. 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.

Trinity Health, as a not-for-profit health system, has the desire and capacity to assume responsibility for more MA and other total cost of care opportunities. 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. We urge CMS, in partnership with Congress, 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.

A. Advance Health Equity
3. What are effective approaches in MA for screening, documenting, and furnishing health care informed by social determinants of health (SDOH)? Where are there gaps in health outcomes, quality, or access to providers and health care services due partially or fully to SDOH, and how might they be addressed? How could CMS, within the scope of applicable law, drive innovation and accountability to enable health care that is informed by SDOH?

CMS and the Administration's emphasis on addressing disparities and advancing health equity aligns with work Trinity Health has been doing internally as well as across our footprint. In the summer of 2020 as the impacts of COVID-19 on minority and underserved communities became clearer, Trinity Health initiated a systemwide effort led by our senior leadership, including our system CEO, to examine our role as a health system in advancing equity across all of our communities. As part of this effort, we have developed a set of principles to guide our journey to health equity, which can be found here. We have engaged representatives from all of our regional health ministries to both develop our guiding principles and to implement these principles locally to reflect each community's unique strengths, challenges, and needs. We believe our experience can provide an example of how health systems can commit to health equity from the very top to all parts of the organization – and work with the communities we serve to shape these efforts.

Trinity Health believes that SDOH data is important to provide a full understanding of and identify community needs and develop strategies to address them. Trinity Health has prioritized collecting information on social needs and invested considerable technical, financial and staff resources to ensure that we have the best information to support our patients and communities. We support CMS in promoting the collection of this data and urge CMS to work with all stakeholders, including plans and providers, to move toward the use of standardized instruments so that comparable data may be collected across health care entities and populations. As the health care system increases efforts to collect SDOH data, providers and plans will need to build experience and invest in staff training to ensure that these sensitive data are collected in appropriate ways that provide individuals with an understanding of why it is being gathered.

We note that CMS recently finalized a requirement in the hospital inpatient prospective payment systems that requires hospitals to report 3 new quality measures on social drivers of health:
- **Hospital Commitment to Health Equity**
- **Screening for Social Drivers of Health Measure** (food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety).
- **Screen Positive Rates for SDOH Measure** (food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety).

Although Special Needs Plans will collect information on housing stability, food security and access to transportation in their Health Risk Assessments in 2023, the agency may want to consider whether similar measures are appropriate for collection of SDOH data by other Medicare Advantage health plans. We also

urge the agency to consider how information about social drivers of health that are collected by plans might be shared with providers to support efficient data collection and delivery of care that meets a patient's needs.

B. Expand Access: Coverage and Care
5. What role does telehealth play in providing access to care in MA? How could CMS advance equitable access to telehealth in MA? What policies within CMS' statutory or administrative authority could address access issues related to limited broadband access? How do MA plans evaluate the quality of a given clinician or entity's telehealth services?

Telehealth can play a pivotal role in providing access to care in MA and MA plans should be flexible in allowing their providers to use telehealth as a central part of their care services. Beginning in plan year 2020, CMS allowed MA plans to include telehealth benefits in their basic benefit packages, as well as in their supplemental benefits. This flexibility provides MA plans with the ability to offer expanded telehealth coverage to meet the needs of their patients, which Trinity Health has found to be essential to our care delivery during the COVID-19 PHE.

The COVID-19 Public Health Emergency has enabled the Department of Health and Human Services to provide temporary flexibilities to make telehealth services more readily available, relaxing long-existing barriers to providing care through telehealth. These telehealth changes limited patient and provider exposure to COVID-19, preserved personal protective equipment, and improved access to care. In addition, these flexibilities have allowed patients with chronic conditions critical access to their physicians. The positive experience Trinity Health has had with the increased adaptation and expansion of telehealth across our health system makes it clear that telehealth is a critical component for how we provide high quality, patient-centered care moving forward.

Trinity Health urges Congress and the Centers for Medicare and Medicaid Services to implement policy changes across systems –including Medicare Advantage and FFS, and Medicaid when appropriate—that support the permanent continuation of telehealth flexibilities to enable an efficient and equitable health care system. This includes advancing policies that ensure access to affordable broadband, technology resources, and telehealth services for communities that experience racial & ethnic health disparities and other underserved populations.

CMS could also incentivize MA plans to implement programs that expand access to essential services in areas where there are barriers to care through telehealth. For example, CMS could encourage plans to adopt programs that help expand access to primary care services in areas where there is limited or no broadband, including initiatives such as through mobile medical units or primary care locations that connect patients virtually to a specialist if that particular specialist does not practice in the area. For example, one of Trinity Health's facilities in Iowa does this and patients are able to drive to a primary care office and primary care staff collect vitals, medication lists, and then connect the patient with a specialist all from that one site, helping to remove the barrier that lack of broadband access can have on care.

10. How do MA plans use utilization management techniques, such as prior authorization? What approaches do MA plans use to exempt certain clinicians or items and services from prior authorization requirements? What steps could CMS take to ensure utilization management does not adversely affect enrollees' access to medically necessary care?

Many MA plans 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 Centers for Medicare and Medicaid Services' (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. CMS could take the following steps to reduce the impact of improper utilization management techniques by MA plans and other plans that the agency oversees, while still ensuring program integrity.

CMS should standardize prior authorization requirements and processes across its programs:

- Set standard thresholds for prior authorization.
- Standardize the format for communicating services subject to prior authorization.
- Standardize the format and content for prior authorization requests and responses.
- Require 24/7 prior authorization capabilities by insurers.
- Establish standard timelines for responses by insurers.
- Require full and complete denials in writing.
- Standardize appeals process with opportunity for external review performed by an independent entity with no relationship to the MA plan or provider.

CMS should increase oversight of insurers to stop inappropriate payment delays and denials:

- Set standard thresholds for payment denials.
- Implement financial penalties for inappropriate denials.
- Test provider network adequacy.
- Publish performance data to compare insurers.
- Increase frequency of insurer audits.
- Increase oversight to determine insurers that are exceeding established standard performance.
- Impose penalties for insurers not in compliance with standard performance thresholds.
- Require insurer policies and utilization management programs to be standardized, such as use of Milliman Care Guidelines, and transparent, including information required from providers.
- Require inpatient coverage for admissions that meet the Two Midnight Rule.
- Require outpatient coverage and payment for admissions that don't meet the Two Midnight Rule.
- Extend direct oversight over MA Plan subcontractors that perform administrative functions on behalf of MA Plans.
- Require insurers to appropriately reimburse for sepsis in a manner consistent with the CMS quality measure.

Finally, 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. Trinity Health is the leading health system implementing value-based care, with nearly $11 billion in cost of care accountability for approximately 2 million patients including 275,000 lives in Medicare accountable care organizations (ACOs) and 165,000 lives in Medicare Advantage models.

There are examples of member-centered health insurers that use fair practices, including MediGold as outlined earlier in our comments. Consistent, transparent, industry standard practices are best for patients, providers and taxpayers.

11. What data, whether currently collected by CMS or not, may be most meaningful for enrollees, clinicians, and/or MA plans regarding the applications of specific prior authorization and utilization

management techniques? How could MA plans align on data for prior authorization and other utilization management techniques to reduce provider burden and increase efficiency?

As noted above, CMS should standardize prior authorization requirements and processes. To do this, we recommend the following:

- Set standard thresholds for prior authorization, require MA plans to publish data on how often prior authorizations for specific services are approved, and limit the use of prior authorization for services that are generally approved.
- Standardize the format for communicating services subject to prior authorization and require plans to make this information easily accessible to providers.
- Standardize the format and content for prior authorization requests and responses with reasonable limits on the scope of documentation required.
- Require 24/7 prior authorization capabilities by insurers.
- Establish standard timelines for responses by insurers.
- Require full and complete denials in writing.
- Standardize appeals process with opportunity for external review.

Additionally, as outlined above, CMS should increase oversight of insurers to stop inappropriate payment delays and denials, through the following approaches:

- Set standard thresholds for payment denials.
- Implement financial penalties for inappropriate denials.
- Test provider network adequacy.
- Publish performance data to compare insurers.
- Increase frequency of insurer audits.
- Develop standards for insurers to follow with respect to attributing members to physicians and also with respect to determining risk adjustments for members.
- Increase oversight to determine insurers that are exceeding established standard performance.
- Impose penalties for insurers not in compliance with standard performance thresholds.
- Require insurer policies and utilization management programs to be standardized and transparent, including information required from providers.
- Require insurers to appropriately reimburse for sepsis in a manner consistent with the CMS quality measure.

C. Drive Innovation to Promote Person-Centered
2. What are the experiences of providers and MA plans in value-based contracting in MA? Are there ways that CMS may better align policy between MA and value-based care programs in Traditional Medicare (for example, Medicare Shared Savings Program Accountable Care Organizations) to expand value-based arrangements?

As outlined above, Trinity Health supports the movement to value-based care and 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. Trinity Health believes that assuming total cost of care accountability can support improved outcomes and dramatically reduce costs by delivering the right care, in the right setting, at the right time.

We are working to advance innovative efforts that support creation of a people-centered health system that delivers value-based care. As noted earlier, Trinity Health is the leading health system implementing value-based care, with nearly $11 billion in cost of care accountability for approximately 2 million patients across markets, including 275,000 lives in Medicare accountable care organizations (ACOs) and 165,000 lives in Medicare Advantage models. Since 2016, Trinity Health's national ACOs and its bundled payment programs have saved the federal government $216 million. We also have one of the largest national Medicare accountable care organization (ACO) portfolios delivering year-over-year savings with top quality. Further, our ACOs were recently recognized with a high score of 97.4% for quality and clinical outcomes.

The value-based arrangements we participate in help develop innovative and community-based services that serve our patients. Examples of these services range from programs to reduce health risks (such as programs for diabetes prevention and treatment) to those that address patient social needs (e.g., transportation, housing, employment, food security, nutrition, etc.) and community-level social influencers of health. These innovative services improve the overall health of patients, reducing unnecessary or avoidable hospital and emergency department visits as well as the overall cost of health care. Our participation in these types of arrangements spans across markets and we believe that there is greater opportunity for expansion of these value-based contracting arrangements within Medicare Advantage.

Based on our experience, we believe that CMS should require or incentivize MA plans to adopt value-based contracting arrangements and participate in total cost of care accountability models with providers. Importantly, the understanding of variances in current MA value-based care models by payers. Within that the key will be how to remove the inherent disadvantages to providers by normalizing for factors that work against value-based arrangements with providers – (1) the administrative efficiencies or lack thereof, (2) margin expectations of health plans/MA organizations, (3) investments made by MA organizations in membership growth by enhancing benefits example the variances in Medicare Advantage Competitive Value Added Tool (MACVAT), (4) bonus payment differences plan to plan for measures that providers do not control but additive to overall STARs measures.

Further, CMS can and should align policies across MA and Medicare FFS value-based payment models as this will support access to value-based care that aims to improve outcomes and reduce costs. More specifically, we recommend, CMS align ACO and Medicare Advantage program requirements/flexibilities including benchmarks, risk adjustment, and the ability to offer supplemental benefits. Our current experience with MA value-based payment arrangements are mixed and mostly negative because MA organizations retain majority of the healthcare dividend that providers generate through not so favorable contract terms with provider, variances in value based care models and importantly the financial impact because of the factors described above.

5. What is the experience for providers who wish to simultaneously contract with MA plans or participate in an MA network and participate in an Accountable Care Organization (ACO)? How could MA plans and ACOs align their quality measures, data exchange requirements, attribution methods and other features to reduce provider burden and promote delivery of high-quality, equitable care?

As discussed above, Trinity Health recommends CMS work to align policies and terms of value-based models (especially quality/quality scores, risk scoring methodologies), across MA and Medicare FFS value-based payment models. We believe this will support improved patient care, ease provider burden by streamlining processes and metrics and support the movement to value-based payments. Specifically, we recommend

that through guidance and regulation CMS should work to advance alignment of ACO and MA program requirements/flexibilities including benchmarks, risk adjustment, and the ability to offer supplemental benefits albeit standardization and full transparency on cost impacts of supplemental benefits to Total Cost of Care value proposition for physicians and providers. Alternatively, a collaboration with providers on how much of the savings can be invested back in enriched benefits.

We also recommend CMS promote alignment and streamlining of beneficiary attribution methodologies, quality measures, reporting and risk score methodologies, administrative billing, historical claims data (medical, pharmacy, others including supplemental) and automated documentation and reporting requirements across insurers and programs as this will decrease provider burden, barriers to participation in value-based models and ultimately extend value-based care to more patients. In terms of attribution, we also recommend CMS incentivize beneficiary alignment to providers participating in value-based arrangements to support greater movement of beneficiaries into these models. We have found that lack of alignment across MA and ACOs has created provider burden and can disincentivize participation—which has negative impacts for patient care.

6. Do certain value-based arrangements serve as a "starting point" for MA plans to negotiate new value-based contracts with providers? If so, what are the features of these arrangements (that is, the quality measures used, data exchange and use, allocation of risk, payment structure, and risk adjustment methodology) and why do MA plans choose these features? How is success measured in terms of quality of care, equity, or reduced cost?

We support the Administration's exploration of ways to align MA and the traditional Medicare value-based model portfolio. The driving principles for future policy should emphasize stability, transparency, and predictability in payment models. In addition, where possible, elements of financial and quality accountability should be aligned so that ACOs in traditional Medicare models can compete on a level playing field with MA plans.

To create greater harmony and more competition across traditional Medicare and MA value arrangements, CMS should consider opportunities to bring greater stability and transparency to the Innovation Center ACO portfolio. Specifically, there may be opportunities to share more information with stakeholders and provide opportunity for feedback publicly, without the formality of notice and comment rulemaking – borrowing lessons learned from MA as it grew to its current size. In addition, making the materials related to model design and any changes to model features more broadly available to the public would support more robust dialogue and more robust analysis of opportunities to participate in these models in the future. Finally, minimizing mandatory mid-year adjustments would bring greater stability to the Innovation Center model portfolio, creating a more attractive option as providers consider their value-based care participation options.

We also urge CMS to align risk adjustment methodologies to the greatest extent possible, to ensure that there is a level playing field for ACOs and MA in terms of the financial models available in each program. We believe that there is an opportunity to streamline traditional Medicare ACO quality measures with MA to minimize administrative burden for providers. We also urge CMS to consider the burdens placed on ACOs that may be greater than what is required in MA. One recent example is the forthcoming implementation of electronic Clinical Quality Measures (eCQMs) for ACOs.

Further, we recommend CMS work with MA plans to implement payment arrangements that create shared savings. Additionally, CMS should work with plans to structure payments to support comprehensive delivery

of sustainable, effective, high-quality services across the care continuum and move away from fee-for-service based models. For examples MA contracts could include incentive or prospective payments to support innovative partnerships and coordination between health care providers and other service providers that increase access to care (e.g. ride share, community health workers). This could also include adoption of population-based payment models that integrate providers across the care continuum and incorporate successful innovations from models such as the Next Generation ACO and Medicare Shared Savings Program.

D. Support Affordability and Sustainability
1. What policies could CMS explore to ensure MA payment optimally promotes high quality care for enrollees?

First, as noted above, we strongly recommend that CMS encourage or require MA plans to participate in value-based payment arrangements and total cost of care models with providers as this will support delivery of care that improves quality and outcomes for patients. As outlined earlier, to incentivize adoption and participation by providers, we recommend CMS take steps to reduce provider burden and barriers by aligning certain requirements across MA and ACOs (see comments above). CMS should also consider working with plans to institute an array of models with different levels of accountability or risk to allow providers with varying experience with value-based care arrangements – small, rural, and safety net providers, including critical access hospitals – to participate, which could expand the reach of value-based care to more enrollees.

Additionally, CMS could provide guidance or technical assistance to plans to support them in structuring payments that advance comprehensive delivery of sustainable, effective, high-quality services across the care continuum and move away from fee-for-service based models. This could include outlining how MA plans may use incentives or prospective payments to support innovative partnerships and coordination between health care providers and other services.

Finally, we recommend that CMS support enrollment of beneficiaries who are dually enrolled in Medicare and Medicaid into financially integrated care models, such as DSNPs.

Conclusion
We appreciate CMS' ongoing efforts to improve payment and delivery systems. If you have any questions on our comments, 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