Trinity Health

May 28, 2023

Chiquita Brooks-LaSure, Administrator
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Re: CMS-4207-NC; Medicare Program; Request for Information on Medicare Advantage Data

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

Dear Administrator Brooks-LaSure,

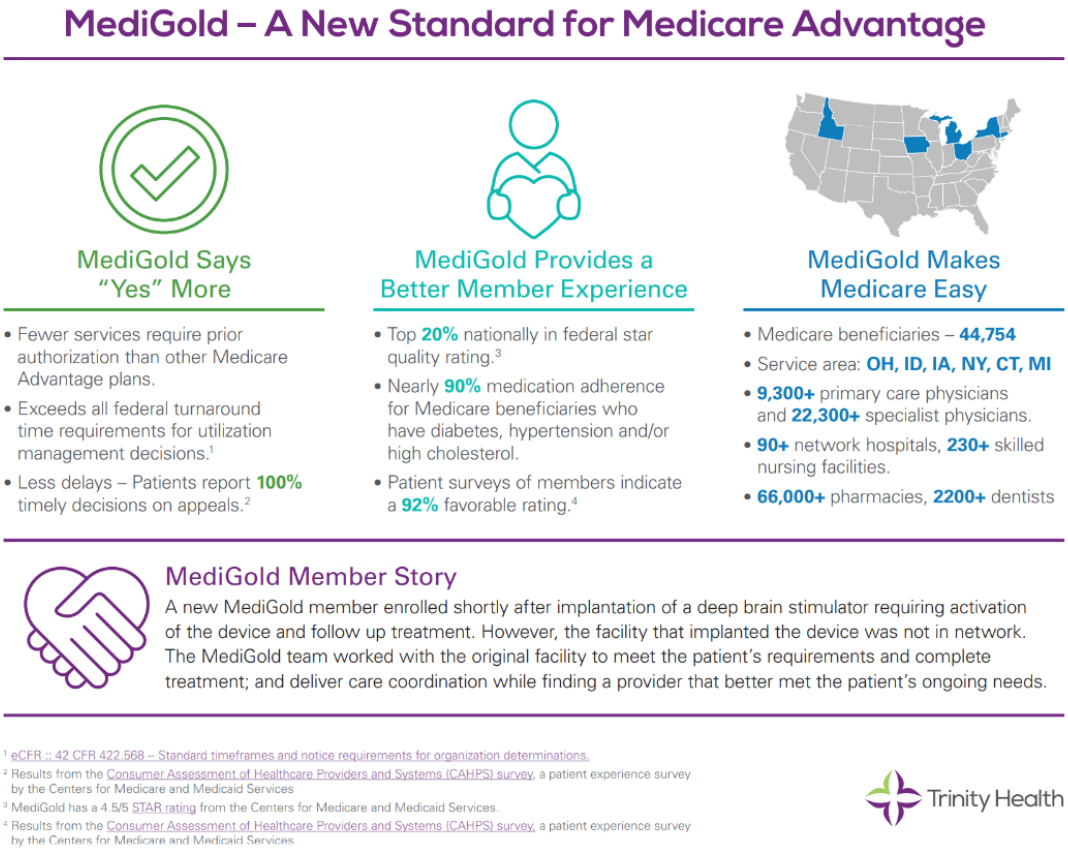
Trinity Health appreciates the opportunity to comment on the questions set forth in CMS-4207-NC. Our comments and recommendations reflect a strong interest in public policies that support better health, better care and lower costs to ensure affordable, high-quality care for all, especially among vulnerable populations.

Trinity Health is one of the largest not-for-profit, Catholic health care systems in the nation. It is a family of 121,000 colleagues and nearly 36,500 physicians and clinicians caring for diverse communities across 27 states. Nationally recognized for care and experience, the Trinity Health system includes 101 hospitals, 126 continuing care locations, the second largest PACE program in the country, 136 urgent care locations and many other health and well-being services. In fiscal year 2023, the Livonia, Michigan-based health system invested $1.5 billion in its communities in the form of charity care and other community benefit programs. Trinity Health is committed to serving as a critical provider in our communities and coordinating care across settings and the care continuum, with 49% of our revenue coming from Medicare and 20% from Medicaid and uninsured patients.

Trinity Health is a strong proponent of value-based care delivery. We have 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 11 markets partnering in one national MSSP Enhanced Track ACO, Trinity Health Integrated Care. All of these markets participate 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 participated in the Bundled Payments for Care Improvement Advanced (BPCIA) initiative and the Comprehensive Care for Joint Replacement (CJR) program across 37 hospitals. 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, Trinity Health owns a non-profit, mission-focused MA plan—MediGold—that plays a vital role in our integrated delivery network and provides care coordination for patients while using fair practices. Serving 44,754 number of beneficiaries across 6 states, MediGold is a highly-effective best practice plan model.

MediGold has a lower profit margin and lower administrative costs compared to commercial for-profit plans because they say “yes” more to providers and beneficiaries. In addition, MediGold utilizes standard and transparent guidelines for decisions on precertification and other authorization approval processes, removing ambiguity of guidelines for providers. In addition, MediGold limits the services that require prior authorization (for example, no prior authorization is required for contracted radiology and contracted skilled nursing facility care) and exceeds all federal turnaround time requirements for utilization management decisions. In fact, patients report 100% timely decisions on appeals. For services that require prior authorization, MediGold has fewer denied claims than for-profit MA plans. Not only has MediGold differentiated themselves from for-profit MA plans; they have done so while maintaining high quality scores (top 20% nationally in federal Star quality rating) and strong beneficiary satisfaction (beneficiaries report a 92% favorable rating of the plan).



Trinity Health appreciates CMS’ continued efforts to improve the practices of Medicare Advantage plans. This is critical, as more than 50% of Medicare beneficiaries are enrolled in a Medicare Advantage (MA) plan, an increase of 26% since 2010. The concentration of MA enrollment is in a few large for-profit plans. United Healthcare, Humana, and Aetna CVS Health had 58% of all MA enrollees in 2023. Notably, these plans reported profits in the hundreds of billions of dollars in fiscal year 2023; with profits from these plans coming at a cost to patients and providers through utilization controls, low reimbursement, and payment denials. Given the continued rapid growth and proportion of the Medicare market, policymakers must ensure MA plan guidelines allow patients to access necessary care, improve health outcomes, and reimburse providers fairly.

Data-related recommendations related to beneficiary access to care

We recommend CMS align equity measures between ACOs and Medicare Advantage plans. Currently, we track equity in HTN 2 – the Hypertension Well-Controlled metric and we have conducted a pilot to improve health equity results in the ACO population for colorectal cancer screening. We urge CMS to include diabetes, hypertension, and cancer screening metrics as equity measures for MA plans.

In addition, we also encourage CMS to require MA plans share data on value-based care arrangements consistent with Health Care Payment Learning & Action Network (hcp-lan.org) measurement and make that data is publicly available. This reporting may also serve as data to be used to develop a baseline for any future incentive for MA plans to enter into value-based contracts with providers.

Insight on ways in which CMS could leverage existing private sector data

To ensure providers receive data in a similar manner to traditional Medicare, we recommend CMS:

- Release the MA encounter data in the same timeline and format as FFS data, including as Research Identifiable Files (RIFs) and through the Virtual Research Data Center (VRDC).
- Include MA data in the CMS Physician Supplier & Beneficiary Summary public use file (PUF), disaggregated with separate columns for traditional Medicare and MA.

Utilization management data

Given the abuse of utilization management strategies from some MA plans, we recommend CMS collect the following data points to help inform which plans are bad actors and are adding waste into the health care system:

- The total number denials, the number of denials that are ultimately overturned, and data that would capture payment downgrades.
- The total number of denials that result in no payment for services.
- The timeframe between a provider appeal and decision for reimbursement.
- Data on the average length of time between claim submission and claim payment.

Trinity Health urges CMS to require plans who are abusing the utilization management process, with the inclusion of denied ED services in the scope of “abuse”, to go through the Independent Review Organization (IRO). CMS can define these plans in regulation as those who are in the top quartile of denials.

New regulatory requirements

CMS should collect from the MA plans information to evaluate their compliance with certain requirements in the CY24 final MA rule, with an emphasis on prior authorization, utilization management, and beneficiary access to benefits.

For the new rule requirement that MA Plans must comply with the Two Midnight Benchmark & CMS Inpatient-Only List, CMS should collect:

- Total no. of denials and payment downgrades issued for inpatient (IP) stays lasting two or more midnights
- Total no. of denials issued for IP stays lasting three or more midnights
- Total no. of denials issued for IP stays for items/services on the CMS Inpatient-Only List

For the new rule requirement that MA organizations that use utilization management (UM) policies and procedures, including prior authorization, must establish a UM committee and adhere to certain requirements. CMS should collect:

- How many members are on the UM committee (CMS does not require a minimum)
- How many are practicing physicians?
    - What are their specialties/clinical backgrounds?
- For physician members, how many years did they practice?
- Did any member of the UM committee report a conflict of interest during the calendar year?
- Did any member of the UM committee recuse himself/herself during the calendar year?
- For organizations that operate multiple MA plans (i.e., parent organizations), do the UM committees sitting at the plan level vary or is the makeup of the UM committees the same across all of the MA plans operated by the parent organization?
- To the extent the MA plan has UM policies or procedures for basic benefits, has the UM committee reviewed and approved them?
    - How many items or services categorized as basic benefits require prior authorization?
- To the extent the MA plan has UM policies or procedures for supplemental benefits, has the UM committee reviewed and approved them?
    - How many items or services that categorized as supplemental benefits require prior authorization?
- What modifications, if any, did the UM committee make to the MA plans UM policies and procedures?
    - If no modifications were made, explain
- Did the UM committee remove requirements for UM for services and items that no longer warrant UM? If yes:
    - How many?
    - Identify the services

CMS collects a significant amount of data and should aim to reduce administrative burden. We recommend CMS review and evaluate what is already collected to determine whether it is all useful and necessary prior to implementing any new data requirements.

Conclusion

The you for the opportunity to comment. 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