

June 29, 2023

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–2439–P; Medicaid Program; Medicaid and Children’s Health Insurance Program (CHIP)
Managed Care Access, Finance, and Quality

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

Dear Administrator Brooks-LaSure,

Trinity Health appreciates the opportunity to comment on policies set forth in CMS-2439–P. 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, especially among vulnerable populations such as those covered by Medicaid.

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 is committed to serving as a critical provider in our communities and coordinating care across settings and the care continuum, with 41% of our revenue coming from Medicare and 18% 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. We have 1 million lives in commercial and Medicaid alternative payment models and we seek more contracts with Medicaid where we have

accountability for cost and care, like the value-based agreements we hold in Idaho, Oregon and Massachusetts. Trinity Health has been an active participant in the development of the Idaho Department of Health and Welfare's Medicaid value care organizations (VCO).

Driven by the belief that everyone should have access to health care coverage, Trinity Health views Medicaid coverage as key to making people-centered care possible. We recognize the importance of the Medicaid program and work to deliver high-quality, accessible, equitable care to the Medicaid beneficiaries we serve regardless of whether they receive benefits through fee for service or managed care.

Trinity Health supports many of the goals CMS' outlines in the "Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality" notice of proposed rulemaking. In general, Trinity Support's CMS' aim to:

- Advance access and high-quality care
- Increase transparency and stakeholder engagement
- Encourage the movement to value-based care delivery and payment
- Align standards and processes across programs and delivery systems, to the extent feasible and appropriate

Below, we offer detailed comments on select provisions organized by section of the proposed rule..

Finally, we strongly urge CMS to give stakeholders the opportunity to comment on any proposed policies before finalizing proposals that may impact access to necessary providers and high-value care.

A. Access

Enrollee Experience Surveys

CMS proposes to require states to conduct enrollee experience surveys and add this to current monitoring system requirements.

Trinity Health supports CMS' goal of ensuring that Medicaid managed care plans have adequate networks to support access to necessary services and to meet Medicaid beneficiaries' health care needs. However, Trinity Health strongly recommends that CMS and its state partners work to ensure that surveys developed and implemented by states solicit meaningful data that can appropriately support assessments of access and network adequacy. If surveys are conducted, we recommend that CMS monitor the implementation of the survey to ensure that the cost and burden of administering the survey does not defray from the costs of care and result in negative, unintended consequences that ultimately impact access to care and services. If costs associated with developing and administering the surveys are significant, CMS could consider bi-annual surveys.

Appointment Wait Time Standards

CMS proposes to create maximum appointment wait time standards for routine appointments for primary care (adult and pediatric), obstetric/ gynecological services, outpatient mental health and substance use disorder services, and a state-selected service (adult and pediatric). CMS also

proposes to require that when a state reviews an exceptions request to the wait time standards that it consider the payment rates that a plan pays to the relevant providers (e.g., those subject to the exception).

Trinity Health agrees wait times and their impact on access is an area of concern. There are many factors that impact wait times, including the significant health care workforce shortage and underpayment by the Medicare and Medicaid programs. Trinity Health does not recommend CMS finalize the wait time penalties as proposed and instead encourage wait times within guidance and work to address the root causes of wait times. In addition, Medicare and Medicaid payment for physicians must improve to encourage access and health equity.

Secret Shopper Surveys

CMS proposes to require states use an independent entity to conduct annual secret shopper surveys to validate the accuracy of managed care plans' electronic provider directories for primary care providers, obstetrical and gynecological providers, outpatient mental health and substance use disorder providers, and a provider type selected by the state. Secret shopper surveys would, at a minimum, assess the provider's active network status, street address, telephone number, and if they are accepting new patients. These surveys would also assess compliance with appointment wait time standards proposed in this rule.

Trinity Health supports CMS' intent and believes this is an appropriate approach to monitor provider directory accuracy. However, we recommend that as CMS and states implement this survey, they ensure that the cost of developing and administering the survey at the state-level does not take needed funds away from care and create negative, unintended consequences that ultimately impact access to care and services. Trinity Health also supports including an assessment of whether or not providers are accepting new patients as part of the survey as this can often be an issue for patient access and a good determiner of network adequacy.

Assurances of Adequate Capacity and Services—Provider Payment Analysis

In response to limited transparency into provider payment rates, CMS proposes a process for plans to report to states provider payment rates for primary care services, obstetrical and gynecological services, outpatient mental health and substance use disorder services, homemaker services, home health aide services, and personal care services—if covered by the managed care entity. States would be required to review and analyze the reported payment rates as part of its oversight of network adequacy and enrollee access and the payment analysis would be submitted by the state to CMS.

Trinity Health supports CMS' proposal. CMS may also want to consider if there are ways to ensure transparency into access and capacity issues that may be occurring within a subset of regions within a state.

Remedy Plans to Improve Access

CMS proposes a process that would require states to submit to CMS a plan to remedy managed care plan access issues when identified. Specifically, once a plan's access issue has been identified – by CMS, the state, or plan—the state would be required to develop a remedy plan and submit it to

CMS within 90 days. The plan would identify specific steps and timelines to remedy the issue(s) within 12 months.

Trinity Health supports CMS' intent to establish a process for states to address identified access issues. However, we believe the proposed timeline of requiring states to develop and submit a plan to CMS within 90 days and address issues within 12 months may be too long. If access issues are identified and Medicaid patients are experiencing significant access issues that could impact their health, we believe that action is needed before 90 days and 12 months. As an alternative to what CMS is proposing, we recommend that states submit a remedy plan to CMS within 30 days and take steps within 3 months or 6 months to resolve the identified issue. Additionally, we also recommend that CMS clarify that access issues identified in credible reports from private entities be considered sufficient to initiate a remedy plan.

B. State Directed Payments (SDPs)

Non-Network Providers

Current State Directed Payment regulations only permit adoption of a fee schedule amount or uniform rate increase for a plan's in-network providers. CMS proposes to remove this restriction to allow SDPs that adopt a fee schedule amount or uniform rate increase to include payment for out-of-network providers.

While Trinity Health understands CMS' aim to increase access to out-of-network providers where there may be limited access to providers generally, Trinity Health is concerned that this proposal would weaken incentives for plans to negotiate with providers to serve in-network. We believe that this would lessen providers' already limited negotiating power in a way that could exacerbate patient access issues.

Establishment of Payment Rate Limitations for Certain SDPs - Proposed Payment Rate Limit for Inpatient Hospital Services, Outpatient Hospital Services, Qualified Practitioner Services at AMCs, and NF Services

CMS proposes that the total payment rate for each SDP for select services—inpatient hospital, outpatient hospital, nursing facility, and qualified practitioner services at an AMC—could not exceed the average commercial rate (ACR). Specifically, when a state has not demonstrated that the total payment rate is at or below the Medicare FFS rate, the state would be required to demonstrate that the total payment rate does not exceed ACR by submitting an ACR demonstration and a total payment rate comparison between the SDP and the ACR.

Trinity Health appreciates that CMS appears to be setting the payment rate limit for certain SDPs at the ACR by using the rationale that this will ensure payment rates are "reasonable, appropriate and attainable." However, as a safety-net provider, ensuring sufficient payment to cover the cost of care delivery is essential, especially for our Medicaid and Medicare populations, and we do not believe that using the ACR will be sufficient to support access to care in all regions.

We understand that [MACPAC](#) has reported that the ACR is higher than Medicare FFS payment rates. However, based on our experience, rates in the commercial market have been largely unregulated, and can be quite variable. These issues can create challenges for comparison purposes and for ensuring fair payment. This has particularly been an issue in regions where there

are a fewer number of plans, thus creating less competition among plans, which could impact the sufficiency of payment rates and network adequacy. We have also found variation in the adequacy of Medicare and commercial payment by care setting. Trinity Health is also concerned that there may be spillover effects on other services (e.g., PACE) that benchmarks and UPLs in the Medicaid program could impact. Given these dynamics, which could lead to insufficient provider rates for the care delivered, we propose that CMS consider the higher of ACR or 200% of the Medicare FFS rate as the ceiling for total payment rates for the selected services.

Finally, CMS includes an extensive discussion of potential alternative methodologies not based on the ACR as a total payment rate limit. These alternatives include Medicare levels or a percentage of total state managed care spending, which CMS notes it could move forward with in the final rule. We urge CMS to assure payment levels do not undermine access to necessary care. CMS should not make changes to SDPs that would lower allowable payment levels in comparison to current levels. We urge CMS to assure public comment on any proposals before policies are finalized.

Potential Addition of Expenditure Limit for SDPs

CMS notes stakeholder concerns that SDPs may be diminishing the risk-based nature of capitated rates and CMS provides examples of states in which SDPs accounted for growing percentages of total projected capitation rates or capitation rates paid to certain providers. CMS invites comment on imposing a limit on the amount of SDP expenditures, including limiting SDP expenditures to 10 to 25 percent of total costs, which could be applied on a rate cell basis.

Trinity Health believes that CMS' proposal to impose a limit on the amount of SDP expenditures may negatively impact certain states disproportionately. We recommend CMS implement a more complete assessment of the impact across states before moving forward with an expenditure limit and allow for public comment on any policies prior to implementation.

Financing

CMS notes that in reviewing SDP proposals, it is encountering issues with state financing of the non-federal share of the SDPs that may not adhere to federal requirements. CMS proposes to revise regulation to explicitly require that an SDP comply with all federal legal requirements for the financing of the non-federal share. States would be required to ensure that every provider participating in an SDP arrangement attests that it does not participate in any hold harmless arrangement related to a health care-related tax.

Trinity Health strongly urges CMS to add more clarity around this proposal before it is finalized. Policies for financing the non-federal share vary significantly across states. If changes are made as CMS proposes, it is important for CMS to clarify to states, beneficiaries, providers, plans and other stakeholders how current approaches to financing may interact with federal regulations as well the implications of CMS' proposal on current financing policies. Clarity is essential before the proposed policies are implemented and before provider attestation requirements go into effect. We urge CMS to engage with safety-net providers to clarify definitions and potential implications prior to finalizing this policy.

Value-Based Payments and Delivery System Reform Initiatives

CMS notes that some current requirements appear to be barriers to implementation of SDPs with VBP initiatives (value-based purchasing, delivery system reform, performance improvement initiatives). As a result, CMS proposes a number of changes to the requirements for SDPs involving VBP initiatives.

Trinity Health is committed to care delivery that both holds providers accountable for the health of the people and communities we serve and advances health equity across populations. We support policies that aim to move more lives and care into value-based care delivery and payment arrangements and we aim to serve as a partner to the CMS Innovation Center, states, plans and others working to advance value-based models. Within Medicaid, we believe in policies that support adoption of value-based care through state directed payments, managed care contracts, Section 1115 waivers and other tools.

Trinity Health is currently participating in value-based payment models within Medicaid, Medicare and with commercial payers. We have 17 Clinically Integrated Networks (CINs) that are accountable for approximately 2 million lives across the country through alternative payment models. We have 1 million lives in commercial and Medicaid 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. Beyond Medicare, we participate in 123 non-CMS APM contracts.

Reporting Requirements to Support Oversight

CMS acknowledges there is lack of data on who is receiving SDPs and that CMS does not consistently or systematically review amounts paid to plans by states or the amounts paid to providers. CMS proposes to use existing plan MLR reporting to states to collect actual SDP expenditure data. CMS also proposes to require states to annually submit data to CMS’ T-MSIS specifying the total dollars spent for SDPs in effect during the rating period by each plan. The reported data would include amounts paid to individual providers.

CMS’ proposals would result in potentially substantial new public, provider-level reporting. Given the complexity of financing and payment, we recommend that provider-level reporting should include elements necessary for understanding payment and related circumstances/context (e.g., providers’ uncompensated care costs and/or Medicaid utilization). This will enable SDPs to be evaluated with sufficient information on the role providers play in the healthcare safety net.

F. Medicaid Managed Care Quality Rating System (§§438.334 and 457.1240)

Establishing and Modifying a Mandatory Measure Set for MAC QRS - Mandatory Measure Set

CMS proposes for public comment an initial set of 18 mandatory measures for inclusion in the Medicaid and CHIP Managed Care Quality Rating System (MAC QRS).

In general, Trinity Health supports a mandatory measure set for the Medicaid and CHIP MAC QRS. We urge CMS to align the measure set for the Medicaid population, where it makes sense for adults, with mandatory measure sets for the Medicare population, as outlined in the [NEJM article, Aligning Quality Measures across CMS—The Universal Foundation](#).

In addition, CMS should align patient experience survey questions across Medicaid and Medicare. Currently, there is variation in mandatory MIPS CAHPS survey questions from the standard set of questions proposed for the Medicaid population. Finally, CMS should consider adopting standard core measure sets that include both primary and specialty care such as the National Quality Foundation CQMC metrics: [NQF: CQMC Core Sets \(qualityforum.org\)](#)

Conclusion

Trinity appreciates this opportunity to comment on CMS–2439–P; Medicaid Program; Medicaid and Children’s Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality notice of proposed rulemaking. We welcome the opportunity to serve as a resource on these issues. Please feel free to contact Jen Nading with any questions at jennifer.nading@trinity-health.org

Sincerely,

/s/

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