Trinity Health

January 31, 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: Request for Information; Essential Health Benefits

Submitted electronically via www.regulations.gov

Dear Administrator Brooks-LaSure,

Trinity Health appreciates the opportunity to respond to questions set forth in CMS-9898-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, 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 participated since 2014 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.

1. Benefit Descriptions in EHB-Benchmark Plan Documents. CMS seeks public comment on its understanding that States have generally proven to be effective enforcers of the EHB requirements. CMS also seeks comment on the extent to which States require additional guidance on how to ensure that plans are interpreting the EHB-benchmark plan documents in a manner that provides EHB coverage to consumers and is consistent with applicable requirements.

- Given the variability across states and plans in terms of the level of detail included in EHB plan documents and benefit descriptions, Trinity Health proposes CMS consider establishing a limited set of national standards for certain features of EHB-benchmark plan documents. Given CMS' assessment that this variation does not appear to impact or harm the consumer, we recommend efforts to standardize plan documents across plans and states aim to allow beneficiaries, states and CMS to more easily understand and compare plans to ensure they will meet needs (in the case of the beneficiary) or EHB standards (in the case of states and CMS), while not increasing burden. A limited set of national standards could include features such as the definition of "medically necessary" as well as covered services for benefits for which there has been noted ambiguity such as the example CMS provides of "radiology services and imaging." CMS could also consider standards for "rehabilitative and habilitative" services.

2. Typical Employer Plans. CMS seeks comment on changes in the scope of benefits offered by employer plans since plan year 2014. Specifically, CMS is interested in comments related to the relative generosity of the current typical employer plans.[1] CMS is also interested in feedback on whether these provisions of the statute are reflective of the scope of benefits provided under employer plans offered in more recent plan years, or whether employer plans offered since plan year 2014 are more or less generous. Finally, CMS seeks comment on whether there are other employer plans commonly sold in States that are not reflected in the current typical employer plans described in these provisions. CMS invited State partners to elaborate on whether changes in State markets since 2014 may warrant changes to the current definition of a "typical employer plan."

- Trinity health believes that the current statute (i.e., §156.100(a)(1) through (4) and §156.111(b)(2)(i)(B)) captures plans that represent the typical employer plan and, as such these are acceptable standards. We think these options are reflective of the scope of benefits provided under employer plans in recent years and believe anything more narrow than these plans could result in limited benefit plans that negatively impact health care and access to care for individuals. Trinity Health also believes that the current definition of typical employer plan and the supplementation hierarchy for the default base-benchmark plan are sufficient and should remain unchanged. Finally, we support the multi-state plans EHB-benchmark established by the Office of Personnel Management (OPM).

3. Review of EHB. In order to maintain its current statutory obligation to periodically review the EHB, CMS seeks comment on the following topics: (1) whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost; (2) whether EHB need to be modified or updated to account for changes in medical evidence or scientific advancement; (3) information on how EHB will be modified to address any such gaps in access or changes in the evidence base; and (4) the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations.

***Barriers of Accessing Services Due to Coverage or Cost*.** CMS seeks comment on whether and to what extent consumers enrolled in plans that provide EHB are facing any difficulty accessing needed services due to coverage or cost.

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[1] Described at § 156.100(a)(1) through (4) and § 156.111(b)(2)(i)(B))

- Behavioral Health. With regards to consumer access to both mental health and substance use disorder services, we recommend CMS consider treating these similarly to services graded as A and B by the U.S. Preventive Services Task Force and cover these at no cost to the patient. We believe removing cost-sharing will support broadened access to behavioral health services and remove barriers to critical care. We also urge enforcement of parity regulations for behavioral health services to ensure all needs are met equitably.

- Telehealth. As has been demonstrated during the COVID-19 public health emergency, policies that have allowed for access to and payment of telehealth services has improved and supported timely access to essential behavioral health care and filled gaps in care. We recommend continuation of policies that allow for access to and reimbursement for tele-behavioral health care including diagnosis and treatment. Similar to our comment above, we believe that cost sharing should be removed for critical in-person behavioral health and tele-behavioral health services. We also support payment parity across in-person and telehealth services.

- Controlling Costs Through Value-Based Care. Trinity Health strongly supports the use of value-based contracting as a way to improve care, quality, outcomes and, importantly, to control the cost of care. Trinity Health supports efforts that advance delivery of value-based care and movement away from fee-for-service and believes that value-based contracting between plans, providers and other partners has been effective in controlling cost of care, while improving outcomes and quality, including for essential health benefits. Trinity Health is actively participating in value-based payment arrangements with Medicare, Medicaid and commercial payers. There is regional variation in implementation of these arrangements, but Trinity Health continues to work to expand use of value-based arrangements and serve as a key partner and leader in the movement to value-based contracting that supports population health management. We have also seen plans use high performance networks to help meet these goals. Notably, through population health management efforts undertaken by Trinity Health's clinically integrated, high-performance networks, we have seen our partner health plans sustain low-cost premium positions in various state Marketplaces for several years.

Problems with utilization management.

- We also view value-based contracting as a way to guard against unnecessary utilization and related costs and support this approach in contrast to other strategies we have seen plans implement that have created access barriers to care. Specifically, some policies related to prior authorization, pre-certification, and utilization management have proven to be barriers in situations where health plans have aggressively implemented policies without assessing the practicality of how care is delivered and what is needed by patients. Between 8 and 10% of Trinity Health's total hospital encounters are routinely denied on first submission, even though documentation denials are almost always eventually approved. We have found that these practices also contribute to health care provider burn out. We have found that in some cases, these policies have led patients to insufficient, downgraded, delayed care or denials, further curbing access to medically necessary care. This impacts the full range of care from diagnosis to treatment to post-acute care. We believe that in some cases health plans are using utilization management and prior authorization policies to suppress appropriate care and generate profitability while unnecessary increasing administrative burden for providers—and, in some cases, plans.

***Addressing Gaps in Coverage*.** CMS seeks comment on how the EHB could be modified to address any gaps in coverage or scope of benefits.

- Essential Benefits Insufficiently Covered. Trinity Health believes that EHB coverage does not always sufficiently include certain services, including telehealth, e-visits, home health services, and remote patient monitoring. We recommend modifications to the EHB to include these services at parity with similar services under each EHB category.

- Habilitative Services. Further, we agree with CMS' assessment that State supplementation of habilitative services within their EHB benchmark plans is inconsistent and we agree that further definition is needed in general to clarify covered benefits. We recommend a national standard around Habilitative Services be established, which would replace the need and practice of state supplementation for Habilitative Services. Habilitative Services should be offered at par with Rehabilitative Services, at a minimum, for services such as PT, OT and ST and this should include coverage that is similar in scope, amount and duration to rehabilitative services. In establishing standard Habilitative Services and what is covered under EHB, CMS should consider recommendations from organizations such AOTA (American Occupational Therapy Association).

- Behavioral Health. As noted above, Trinity Health believes that barriers to behavioral health services exist, and we recommend certain behavioral health services be treated as preventive care. Expanded access could increase early detection to lessen the need for crisis care or stabilization services. Trinity Health supports use of peer support, community health workers and other providers and services, but it has been our experience that peer and recovery support are largely not covered or recognized.

- Chronic Conditions. We believe that existing gaps in coverage of essential services for individuals with chronic and lifelong conditions should largely be covered under preventive care services—primarily offered by primary care providers, when appropriate. Trinity Health strongly recommends and advocates for primary care providers to serve as a foundational component of managing chronic and lifelong conditions. We believe that primary care providers should play a role in managing care related to a range of conditions and services including lab and diagnostic services and medications. We believe that these services should be covered without any cost sharing including by qualified HDHP HSA plans just like other preventive services.
- Ensuring Sufficient Coverage/Addressing Gaps in Coverage. We believe CMS can best balance State flexibility related to enforcement of EHB with the statutory requirement to ensure sufficient coverage for a diverse population through network adequacy and expanded access standards—such as policies that permit use of and reimbursement for telehealth and e-visits. Finally, we recommend that any changes in the evidence base be incorporated into EHB through quality scores—similar to the approach CMS uses with standards for Medicare Advantage plans.

D. Actuarial and Cost-Sharing Limitations. CMS notes that any efforts to change the benefits covered as EHB have the potential to impact costs and the ability of plans to meet the actuarial and cost-sharing limitations under section 1302 of the ACA. CMS invites comments that address the ability of plans subject to EHB requirements to conform benefit designs to these requirements.

- Trinity Health believes that actuarial value (AV) and minimum value (MV) calculators need to be refreshed. We recommend recalibrating them to align with changing healthcare benefits and needs, while still ensuring actuarial values remain in the prescribed ranges under section 1302 of ACA.

4. Coverage of Prescription Drugs as EHB. CMS seeks comment to confirm or further expand on its understanding of the risks and benefits of replacing the current USP Guidelines with a different drug classification system. Specifically, CMS seeks comment on whether it should consider using an alternative prescription drug

classification standard for defining the EHB prescription drug category, such as the USP DC or others, in the future.

- Trinity Health recommends that in addition to having a national standard, a primary drug classification system to be used for EHB that CMS also identifies as secondary guidelines. In cases where a plans' formulary appears to have inadequate coverage or inconsistencies across classes, a secondary guideline such as USP-DC could be used as a reference point for substitution purposes.

5. Substitution of EHB. To the extent the substitution of EHB is not widely used by health plans, CMS seeks comment on how it might revisit rules regarding the substitution of EHB in future rulemaking so that consumers have access to health plans that can better address changing public health concerns or innovation in health care. Alternatively, CMS seeks comment regarding whether health plans should not be permitted to substitute EHB within the same EHB category.

- Trinity Health recommends CMS not allow substitution of EHBs unless the proposed substitution is based on scientific evidence and an analysis of economic benefits including impact on the quality of life of an additional services. These criteria should be applied across benefits including pharmaceutical (including for experimental drugs for rare diseases), preventive care, early diagnostics, alternative therapies, technological advancement in treatment and surgical procedures, and alternative sites of care.

Conclusion

Thank you for the opportunity to comment. If you have any questions, 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