Trinity Health

November 7, 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-2421-P; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes
Submitted electronically via http://www.regulations.gov

Dear Administrator Brooks-LaSure,

Trinity Health appreciates the opportunity to comment on policies set forth in CMS-2421-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.

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.

Streamlining of application, eligibility determination, enrollment and renewal processes

Trinity Health believes access to affordable health care coverage for all is key to making care as people-centered as possible. As such, Trinity Health fully supports the proposed rule that would streamline eligibility and enrollment for Medicaid and the Children's Health Insurance Program (CHIP), including:

- prohibiting annual/lifetime limits on Medicaid and CHIP;
- allowing children to remain enrolled in CHIP without a lock out payment for failure to pay premiums;
- creating a process to prevent termination of eligible beneficiaries who shift between Medicaid and CHIP; and
- requiring that timeliness standards apply at renewal and application.

Additional policies to improve access and quality of care

Legal permanent residents

We urge CMS to work with Congress to remove the five-year bar from coverage for legal permanent residents who are currently not eligible for Medicare (if they are over 65 years of age) and do not have means (employed, self-employed or self-pay) to pay for health care coverage. This would allow this population to obtain care through Medicaid and/or BHP programs.

State licensure, telehealth, remote patient access

We urge CMS and state partners to make permanent flexibilities permitted during the public health emergency, which relaxed state licensure requirements and permitted providers to deliver care across state lines. This would support states' abilities to address workforce challenges and support beneficiary access to key providers regardless of whether they are located in the same state. Second, we recommend CMS and states implement policies to support access to and reimbursement for remote patient monitoring and telehealth, including audio-only visits, which are critical in low-income communities or communities with limited broadband access.

Medicaid provider credentialing across state lines

To improve access to care and reduce administrative burden on providers, Trinity Health recommends CMS require state Medicaid programs to enroll providers utilizing the provider's status in the state where the services are rendered when services are provided across state lines. If a provider meets the criteria for the state in which the service is rendered, they should only have to supply confirmation to the covering Medicaid program and the state or payer should load the status as of the first date of service prompting the request.

Provider incentives

CMS should consider ways to incentivize providers to accept Medicaid patients, which could include encouraging states to implement minimum payment rates that adequately cover the cost of care for the annual physical, immunizations, screenings, and other key services. This would also help ensure beneficiaries have the opportunity to identify health conditions and needs sooner.

Alternative payment models

Trinity Health is committed to care delivery that holds providers accountable for the health of the people and communities they serve and that advances health equity across populations. As part of this commitment, we support implementation of value-based care models that tie payment to improved outcomes, quality, and population health. Our work—and experience in value-based contracting—also extends beyond Medicare as illustrated by our participation in 123 non-CMS APM contracts.

We recommend that CMS continue to work with states to implement value-based payment (VBP) models and arrangements that support population health and accountability for care. To this end, we urge CMS to continue to approve Medicaid Section 1115 waivers or work with the Innovation Center to test models that aim to improve outcomes, quality, and control costs as these programs allow us to integrate care through more innovative approaches, particularly across medical and behavioral health conditions. We are working with

states across our footprint, including New York, Massachusetts, and Idaho, to implement VBP models approved as part of their Section 1115 waivers and would welcome the opportunity to offer insights to CMS.

Additionally, based on our experience, managed care plans have been less likely to develop contracts with providers under VBPs for total cost of care and clinical accountability. We urge CMS to incentivize Medicaid MCOs to implement models that allow providers to share in risk and reward. Similarly, we recommend CMS consider ways to clarify and share best practices or promising approaches across states and MCOs demonstrating how MCOs and providers may share risk for managing total cost of care. We also recommend that CMS establish minimum MLR requirements for managed care plans across all states and urge states with MLR requirements to enforce them.

Conclusion

We appreciate CMS's ongoing efforts to improve access to health programs. 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