



January 11, 2019

Seema Verma, Administrator
Centers for Medicare and Medicaid Services,
Attention: CMS-2408-P
P.O. Box 8016
Baltimore, MD 21244-8013

RE: CMS-2408-P - Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care; Submitted electronically via <http://www.regulations.gov>

Dear Administrator Verma,

Trinity Health appreciates the opportunity to comment on the *Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care* proposed rule. Trinity Health believes that Medicaid is key to making the people-centered care we deliver possible and we have significant experience working within the Medicaid managed care delivery system and serving Medicaid beneficiaries and other vulnerable populations. To this end, our comments and recommendations reflect a strong interest in public policies that support better health, better care and lower costs that ensure affordable, high quality, and people-centered care for all.

Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation, serving diverse communities that include more than 30 million people across 22 states. We are building a People-Centered Health System to put the people we serve at the center of every behavior, action and decision. This brings to life our commitment to be a compassionate, transforming and healing presence in our communities. Trinity Health includes 94 hospitals as well as 109 continuing care locations that include PACE, senior living facilities, and home care and hospice services. Our continuing care programs provide nearly 2.5 million visits annually. Committed to those who are poor and underserved, Trinity Health returns \$1.1 billion to our communities annually in the form of charity care and other community benefit programs. We have 35 teaching hospitals with graduate medical education (GME) programs providing training for more than 2,000 residents and fellows in 184 specialty and subspecialty programs. We employ approximately 133,000 colleagues, including more than 7,800 employed physicians and clinicians, and have more than 15,000 physicians and advanced practice professionals committed to 23 Clinically Integrated Networks (CINs) that are accountable for approximately 1.4 million lives across the country through alternative payment models (APMs).

Trinity Health cares for more than five million individuals covered by Medicaid. We view Medicaid as an important program in all of our communities and value our partnerships with managed care plans, states and other stakeholders. Trinity Health thanks CMS for the opportunity to respond to this proposed regulation and intend for our comments and recommendations, which are outlined in more detail in the attached, to reflect our strong interest in public policies that support people-centered care for all.

If you have questions on our comments, please feel free to contact me at granttw@trinity-health.org or 734-343-1375.

Sincerely,

Tina Weatherwax Grant, JD
Vice President, Public Policy and Advocacy

Trinity Health Comments on *Medicaid Program; Medicaid and Children’s Health Insurance Plan (CHIP) Managed Care*

Trinity Health appreciates CMS’ ongoing efforts to support the delivery of value-based care and reduce administrative burden and we support several provisions in the proposed rule to advance these goals. However, we are concerned that a number of proposals may diminish beneficiary protections and increase administrative burden. As such, we offer the following general comments on this proposed rule, including the following three main points.

- 1. Support Provider-led Medicaid Innovation and Value-Based Payment and Care.** First, we applaud CMS’ efforts to support development and implementation of value-based payments that drive high-value care within Medicaid and across payers. We believe innovation within the Medicaid program is critical for states to implement public policies that support these goals while ensuring affordable, high-quality, people-centered care for all. To this end, we support efforts in this proposed rule that give greater flexibility to states to implement value-based payment arrangements and multi-payer models.

However, based on our experience in Medicaid, Medicare and commercial value-based payment models, we have learned that providers are essential in developing and implementing successful alternative payment models that drive high-value, integrated, population-health focused care. We urge CMS and other payers to partner with providers to develop innovative, integrated value-based models. Trinity Health welcomes the opportunity to continue to work with CMS, states, managed care plans, and community-based providers to develop models that advance whole person-centered care across physical, behavioral and social determinant of health needs.

- 2. Reduce Administrative Burden for Providers and the Health System.** We are concerned that some of the policies in the proposed rule will increase administrative burden for plans and providers—which is in contrast to CMS’ goals of reducing administrative and regulatory burden. Specifically, we believe that proposals allowing for greater variation across states for managed care network adequacy standards and in the definition of “specialists” are likely to create additional burden for plans and providers providing coverage or care to Medicaid beneficiaries across multiple states.
- 3. Strengthen Beneficiary Protections to Ensure Appropriate Access to Care.** Finally, we are concerned that multiple provisions in the proposed rule—specifically those related to network adequacy standards and information requirements—weaken beneficiary protections that are necessary to ensure access to critical providers, care and information about coverage.

Below, we offer more detailed comments informed by our experience partnering with states, managed care plans, and community-based providers and service programs that serve the Medicaid population across our health system’s and ministries’ footprint.

Network Adequacy Standards

Trinity Health believes that coordinated, high-value networks are essential to quality, cost-effective care and ultimately lead to improved health. Ensuring patients have access to an adequate network of providers is critical to advancing these goals.

Trinity Health recommends that CMS maintain the requirement that all states establish time and distance standards as part of network adequacy requirements and not replace them with “quantitative network adequacy standards.” We are concerned that CMS’ proposal to allow states to develop “quantitative network adequacy standards” may result in significant variation across states, create barriers to access to critical services and providers, and increase disparities in access to care across states. Further, we are concerned that variation in the types of network adequacy standards that states might develop could create significant administrative burden as plans and providers try to ensure compliance across multiple states.

We urge CMS to maintain the requirement that all states establish time and distance standards as part of their network adequacy requirements. While we understand that it is important that a state’s network adequacy standards consider the state’s geography and the unique needs of the state’s Medicaid population, we believe that time and distance standards most appropriately ensure access to high-quality care.

If states are granted additional flexibility in establishing network adequacy standards, we urge CMS to establish a set of minimum requirements to which states would need to adhere. Such minimum standards could be developed with input from stakeholders.

Additionally, Trinity Health recognizes CMS’ goal of providing state’s flexibility in defining the term “specialist” “in whatever way they deem most appropriate for their programs.” However, we are concerned that variation across states could result in access issues for specialty services and that application of different definitions across states could create additional administrative burden for plans and providers. We have also found that availability of care from specialists has been an issue in some of our states—for example, some specialists listed as in network have not been accepting new patients or have limited their panel size. We urge CMS to maintain current and consistent network adequacy standards across all states. At a minimum, we recommend CMS establish basic standards related to what providers should be included in the definition of “specialist.”

Delivery System and Provider Payment Initiatives Under MCO, PIHP, or PAHP Contracts

Trinity Health shares CMS’ goal of supporting payment models that drive high-quality care, improve population health and lower costs. We support Medicaid innovations that promote these shared goals while maintaining access to coverage and needed care. Our commitment to value-based payment and care is reflected in our participation in Medicaid value-based payment arrangements, as well as Medicare models including the Next Generation ACO, Medicare Shared Savings Program (MSSP) Tracks 1, 1+ and 3, the Comprehensive Primary Care Plus (CPC+) program, and the Bundle Payment for Care Improvement (BPCI) and BPCI Advanced programs.

Trinity Health views states as uniquely positioned to drive health system transformation and improve the health and well-being of our communities and we believe a number of CMS’ proposals further support implementation of value-based payments within the Medicaid program and across payers. **Specifically, we support CMS’ proposed changes that would allow states to direct the amount or frequency of payments made by managed care plans for delivery system or provider payment initiatives. This additional flexibility could support state implementation of value-based payment arrangements and multi-payer models. We also urge states, CMS, and managed care plans to work with providers to explore models that support coordinated, integrated, people-centered care.**

Trinity Health believes in the value of innovative, alternative payment models within Medicaid. However, we believe there is a need for models that allow for greater flexibility in integrating funding across state programs. Programs should foster innovative relationships and participation between CMS, states, providers, community-based organizations and MCOs to advance the development of coordinated care and social services for vulnerable populations – and providers and community-based organizations should be actively involved in these discussions.

For example, the elimination of siloed funding streams could better support the delivery of coordinated physical and behavioral health care, as well as assure the integration of social services (e.g. housing) that address social determinants of health. Based on our experience, siloed funding streams can impede the delivery of integrated, person-centered care for vulnerable individuals and we urge CMS and states to address these issues in the development of innovative payment and delivery programs.

CMS and states should consider other data and tools that can help providers develop value-based payment models, improve programs, and understand performance—such as all-payer claims data bases. Finally, we recommend that CMS, states, MCOs, and providers continue to build on models

that support integrated, population-based care such as accountable care organizations—which allow for integration of care and resources necessary to manage care and costs.

Trinity Health also supports CMS' proposal to permit states to require managed care plans to adopt “a cost-based reimbursement, a Medicare equivalent reimbursement, an average commercial rate reimbursement, or reimbursement based on another market-based standard” for certain network providers that provide specific services under contracts. We believe that allowing states to adopt the identified, alternative rates for certain providers could support state flexibility in implementing payment models that support access and care for the Medicaid population. However, we urge CMS in its oversight to ensure that state adoption of other market-based standards does not impede access to care as a result of inadequate payment.

Finally, we support CMS' proposal to allow for approval of multi-year payment arrangements as it often takes time and investment from states, plans, providers and other stakeholders to implement new payment arrangements. Alleviating the need to submit annual renewals may not only lead to a reduction in administrative burden, but also support the expansion of value-based payment models.

Medicaid Managed Care Quality Rating System (QRS)

Trinity Health strongly encourages CMS to promote alignment across CMS' QRS framework, any state-developed alternative QRS, and quality rating systems within other markets (e.g. qualified health plans, Medicare Advantage), to the extent feasible. We believe this will promote delivery of high-quality care (regardless of coverage type), reduce confusion for beneficiaries transitioning across coverage options or states, and reduce administrative burden for plans participating in multiple states or markets.

Trinity Health also supports CMS' proposals to create a QRS framework with a set of minimum, mandatory performance measures and supports alignment with other quality initiatives as this approach would increase accountability, comparability of plans across states, and reduce administrative burden. **We recommend that the measure set include a limited number of meaningful measures and prioritize patient-reported measures of outcomes, care experience and functional status,** as we know those to be of greatest value. We also recommend the alignment of quality measurement across payers, to the extent this is appropriate. Comparable quality measures across populations can support the development of programs to reduce disparities in care delivery and assure the improvement of outcomes across populations.

Finally, Trinity Health urges CMS to move forward with the development of the Medicaid Managed Care QRS framework as this would help to ensure quality of care across Medicaid managed care plans and provide beneficiaries with information about the plans available to them. We urge CMS to finalize the QRS framework as soon as possible and to issue guidance outlining the process for assessing whether or not a state's alternative QRS aligns with CMS' QRS framework.

Institutions for Mental Disease (IMD)

Trinity Health believes it is essential for individuals to have access to prevention and treatment for mental health and substance use disorders and supports policies and program changes that eliminate restrictions on Medicaid payments for inpatient treatment in large residential facilities. From our experience, the limitations on payments for services at institutions for mental disease (“IMD exclusion”) has led to additional barriers to care, including insufficient capacity at IMDs necessary to meet patients' needs, which can lead to long waitlists and subsequent uncompensated care. We appreciate CMS' recent efforts to work with states to implement policies to address the IMD exclusion via Section 1115 waivers but believe a more permanent solution that removes the limitations on payment to institutions of mental disease is needed. Until there is a permanent resolution to the IMD exclusion, we encourage CMS to continue to prioritize Section 1115 waivers that address the IMD exclusion.

Information Requirements (Language and Format)

Trinity Health is concerned with CMS' proposal to only require that plans include taglines in prevalent non-English languages and in large print on materials that are "critical to obtaining services" instead of "all written materials". Currently, taglines that are required to be large print provide information on "the availability of written translation or oral interpretation, how to request auxiliary aids and services for individuals who have limited English proficiency or a disability, and the toll-free phone number of the entity providing choice counseling services." We are concerned that narrowing the types of materials that are required to have these taglines may impede access to necessary information and care for vulnerable populations. These proposed changes may negatively impact a broader range of Medicaid enrollees beyond those acknowledged by CMS (e.g. those who are visually impaired). Additionally, CMS' proposal to change the definition of large print from "no smaller than 18-point" font--which is based on the American Printing House for the Blind, Inc.'s guidelines—to "a conspicuously-visible font size" may impede access to necessary information among Medicaid enrollees with disabilities. **We strongly urge CMS not to change its policy related to inclusion of taglines in prevalent non-English languages and in large print on all plan materials as we believe that states and plans must ensure that all enrollees and potential enrollees be able to easily access all plan information.**

Conclusion

Trinity Health appreciates the opportunity to comment on the *Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care* proposed rule and we look forward to the opportunity to continue to partner with the administration.