



March 1, 2019

Lamar Alexander
Chairman, Senate HELP Committee
United States Senate
Washington, D.C. 20510

Re: Steps to Address Rising Health Care Costs Request for Information (RFI); submitted electronically via LowerHealthCareCosts@help.senate.gov

Dear Chairman Alexander,

Trinity Health appreciates the opportunity to offer recommendations on how to lower health care costs, improve the health and outcomes of patients, and increase the ability for patients to access information about their care. Our comments are in two parts. First, we provide specific recommendations that would improve the health care system as currently structured, including recommendations for the Center for Medicare and Medicaid Innovation (CMMI) and the Centers for Medicare and Medicaid Services (CMS). Secondly, we urge the Senate HELP Committee to recognize the grave condition of our health care system and the need to take steps to address more fundamental structural aspects of health care financing and administration. Trinity Health recognizes the need for Congress to consider more dramatic approaches to make a significant impact and truly reduce health care costs for American families.

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 18 Clinically Integrated Networks (CINs) that are accountable for approximately 1.5 million lives across the country through alternative payment models (APMs).

Value-Based Arrangements and Provider Payment Reform

To truly transform the delivery and cost of health care, the Department of Health and Human Services and the Congress must continue to push for *all payers*—public and private—to move toward value-

based care. Our comments and recommendations are informed by the significant experience our system has in establishing and supporting CINs and APMs. As an organization, we are committed to rapid, measurable movement toward value in the delivery of and payment for health care, including the assumption of downside risk. Trinity Health has implemented a system-wide strategy to "Build a People-Centered Health System" that is accountable for delivering better health, better care and lower costs for the communities we serve. Our People-Centered 2020 strategy includes initiatives to transform the way we deliver care and the way we are reimbursed, including a system-wide goal of having 75 percent of our revenue flowing through APMs by 2020. Trinity Health participates in 11 markets with Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs), which includes five markets partnering as an MSSP Track 3 ACO. We also have four markets partnering as a Next Generation ACO and 2 participating in CPC+. In addition, we have 33 hospitals participating in the Bundled Payments for Care Improvement Advanced (BPCI Advanced) 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. Through our APMs, Trinity Health is currently accountable for \$9.5 billion in total cost of care for 1.5 million people. We have invested almost \$120 million in APMs, and the majority our downside risk is with Medicare APMs. With this accountability and investment, we are clearly committed to transformation.

There has been significant experience across the industry over the last six years testing APMs; however, there are still many uncertainties and challenges. Trinity Health believes CMMI holds great promise in promoting transparent and consistent model design across all payers; supporting evaluation and measurement of model impacts; and developing market-based innovations that build on promising practices. Trinity Health urges CMS to continue to evolve existing models and programs that drive value-based care—including offering more opportunities for private payers to participate—promote population health and engage beneficiaries. CMMI has been a leader in this work, but significant opportunities exist with data, systems and policy changes.

Financially Sustainable Models Are Imperative

Providers are hungry for programmatic changes that will offer a more promising, predictable and sustainable value opportunity for well-executed programs. CMS should adopt a long-term strategic approach to entice as many providers as possible to participate and invest and develop a sustainable path for health care organizations to transition to a value-based approach, recognizing that ultimately full capitation will allow the complete re-design of care to improve quality and the potential to significantly reduce the cost of care. Specifically, we urge Congress to encourage the Department of Health and Human Services (HHS) and CMS to be more strategic about a path to transformation across all payers, including convening a group of integrated systems and physician organizations to discuss directly with the Administration a path that would take, those of us willing, to full capitation in five years. Trinity Health is very interested in participating as a leader in this strategic approach.

Health care providers, hospitals, physicians and others face a very challenging environment with escalating costs, declining or flat reimbursements, heightened demand for services, and an increasingly complex regulatory environment. At the same time, we are delivering highly proficient and complex care to individuals at their most vulnerable time. Many providers view APMs as having insufficient opportunity and many physician organizations do not have the financial ability to sustain themselves through a negative experience. In addition, they are hesitant to take on downside risk exposure because of negative experiences with similar models in the 1990's and associated

significant losses. Therefore, many are not investing in APMs, creating a false test of the true opportunity that exists therein.

Transforming care requires a fundamental change to (1) provider approaches to care, (2) the size and character of our work force, (3) capital investments, (4) IT systems and (5) virtually all aspects of our operations. Providers need to make significant investments to support and drive these changes under increasing complex requirements. To ensure that providers make the right investments, CMS should develop models that present a reasonable expectation for positive returns and a return on provider investment. The following represent key recognitions and components in creating effective models.

Ensure multi-payer engagement. Transformation should be cross-payer with Medicare, Medicaid, commercial payers, employers and federal and state agencies, all employing available means in the movement towards value. All federal programs—including Medicare Advantage, Veterans Affairs, Department of Defense, and Federal Employees Health Benefits—should align with APMs by requiring participating insurers to meet a defined percentage of their entire business to be operating under APMs. Medicaid programs have implemented promising models, including the recently launched Medicaid ACO in Massachusetts. Policymakers should consider the unique needs of Medicaid beneficiaries and the capacity for providers serving these populations to assume risk, and set expectations at sustainable and appropriate levels. Trinity Health has developed a Medicaid Innovation Resource Center, which includes public policy tools and resources that aim to increase transparency and help stakeholders assess the *impact* of emerging policy trends and innovations on states, beneficiaries and care. In addition to Medicaid innovation, states are ripe for engaging in multi-payer innovations. We urge for continuation of and building on existing cross-payer models, including reinstating state innovation model (SIM) grants—which have expired—given the progress SIM has had in driving state-led health care transformation and innovation.

Increase up-side opportunity for providers. The most effective way for CMS to engage providers is by offering programs that are simplified, predictable and rewarding from inception. CMS can look for shared savings initially, but should expect the majority of the financial impact to be long-term decreases in the Medicare and Medicaid spending trends. Trinity Health recommends a new approach which would attract more ACOs to make these significant investments by offering an opportunity of an 80 percent share in the upside potential with protection against downside financial risk until the three-year mark. At a three-year settlement timeframe (reducing random variation), an ACO must be generating savings to stay in the model. In addition to the more enticing financial terms, we recommend that all of the features associated with the downside risk models, such as robust waivers and prospective beneficiary alignment, should be available to drive savings farther and faster. We appreciate that many of these features were expanded across tracks in the Pathways to Success Final Rule.

Recognize that transformation will take time. Trinity Health's experiences are consistent with the ACO experiences nationwide. It takes several years to put the right operational processes in place and see the impact on the total cost of care. There are few precedents for this approach to transforming an industry, especially one as large and as complicated as health care. The introduction of APMs within traditional Medicare—new payment and delivery approaches—should be viewed as tests of new models whose impact is uncertain. We should not prejudge the outcomes of a particular approach, and we should provide sufficient time for models to be adequately tested. With the implementation of DRG's, for example, it took the industry over 15 years to see the full impact on hospital length of stay. ACOs involve much more complex change affecting many more elements of the delivery system. Policymakers need to provide adequate time for a fair test of these models. Given that reality, we

recommend testing a wide variety of models and seeing what works best. Building on—and fostering greater sustainability of—models that are comprehensive and have demonstrated success in improving quality and reducing costs, while also reducing fragmentation, is critical. Trinity Health specifically encourages evolution of the Next Generation ACO model based on feedback from participating providers, which could powerfully advance common goals. The benefit of optimizing and expanding the Next Gen ACO model is that Next Gen puts the delivery systems at the center of a total cost of care model, where there is the greatest opportunity to deliver on the triple aim through delivery system transformation that keeps the patient at the center of care.

Align ACO and Medicare Advantage rules. Medicare Advantage provides greater transparency and opportunity to manage benchmark and target goals as well as better opportunity to provide care and medical management of a population within a high-performing network, and relative to a market-based benchmark or budget. The flexibility to provide alternative sites of services (i.e. care in the home) and care management capability in Medicare Advantage should be applied into other payment models, including ACOs. Hierarchical Condition Categories (HCC) rules should also be the same for Medicare Advantage and ACOs. This alignment would serve to better support the opportunity for ACOs to drive transformation and reduce Medicare spending, rather than driving providers out of ACOs into Medicare Advantage. Combining the Next Gen model -- where the delivery system is driving transformation --with the payment and benefit advantages of MA would be a powerful combination to manage costs and improve care.

Offer an advanced ACO opportunity path to full capitation over three to five years, while preserving the opportunity to have CMS pay claims. This opportunity recognizes that fully capitated *delivery organizations* have the greatest potential to produce lower costs and higher quality care. We have demonstrated successfully that ACOs are a viable alternative to fee-for-service and payer-based Medicare Advantage models and recommend that CMS consider allowing any ACO that is willing and able to become fully capitated across Parts A, B and D to do so, and to market the ACO product directly to consumers. We believe this model -- combining the best of the NGACO and MA models with delivery systems at the center of transformation -- would allow providers willing to assume full-risk, with CMS remaining as the enrollment and claims payment organization. CMS should look for ways to use ACOs as options for bringing a lower cost approach as compared to Medicare Advantage. Again, we urge HHS/CMS to convene interested stakeholders to develop the strategic imperative towards transformation in order to get, those that are willing, to full capitation in five years. Trinity Health would gladly help convene these stakeholders.

Availability of waivers to ACOs. Trinity Health thanks CMS for providing additional waivers to ACOs in the Pathways to Success Final Rule, including the SNF 3-day waiver, the ability to cover telehealth, and cost sharing waivers for primary care and preventive services. CMS will see ACOs embrace these benefit enhancements if there can be a reduction in the administrative burden of participating. We urge CMS to make additional waivers available including those related to site of care, hospital discharge planning requirements, homebound requirements for home health, and medication copays for drugs that support management of chronic disease and other co-payments that would enable providers to advance the most optimal treatment options available to beneficiaries.

Simplify quality measurement and ensure measures are outcome-based. CMMI can play an important role in testing the use of measures that are well-defined, evidence-based and designed to fill gaps in measurement without adding undue burden on providers. Quality measures used in existing and new models and programs for payment should be reviewed regularly and be limited such that there are no more than five clinical measures and two patient experience measures, and should be aligned across

Medicare programs and private payers. The industry needs to rapidly adopt existing consensus-driven core measure sets to reduce administrative burden that increases healthcare costs and does not add value for patients while working to identify the next generation of core measures. This is critical that the industry advance and adopt patient-reported outcomes measures or PROMs.

Social Influencers of Health

Trinity Health recognizes the overall health of an individual is influenced by a number of factors outside of the health care setting—such as housing, food security, and transportation. Such factors contribute greatly to health outcomes and costs. We are committed to advancing the health of individuals and populations and strongly believe payment and delivery models should support addressing social influencers of health. We recommend CMMI incorporate social influencers of health into new delivery and payment models for all payers. As new models are developed and tested, CMS and other federal agencies should continue to work with state, regional and local stakeholders to find innovative ways to integrate social services into care management programs and foster payment models that support such integration. This should also include adjustment to payment based on sociodemographic factors.

Technology and HIT

Interoperability is a key strategic imperative for Trinity Health. To this end, we are implementing the largest single instance of Epic in the country and are working to move all of our hospitals and continuing care facilities to the platform over the next four years. This will allow us to thoroughly integrate care for all of our patients across the continuums of care and promote the widespread exchange of structured and standardized health information. Further, it helps care providers meet a patient's needs in a more comprehensive and concise manner by eliminating barriers to data sharing and care coordination.

Trinity Health believes strongly that federal leadership and action are needed to move the nation more expeditiously to interoperability. While the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program (now the Promoting Interoperability Program) did successfully drive adoption of EHRs, the program remains largely government-driven rather than patient-centered, which has led to “tick the box” government requirements that have failed to advance patient care, improve clinician workflow, or make the substantial progress toward interoperability that was envisioned when the program was enacted.

Promotion of an effective national strategy for accurately matching patients to their data is critical. One of the primary challenges impeding the safe and secure electronic exchange of health information is the lack of a consistent patient data matching strategy. Consistency in patient data matching is foundational to interoperability and is an essential to patient safety---HHS should promulgate regulations to correct this issue and improve the appropriate and secure flow of health data necessary to promote care coordination and remove barriers to value-based care.

Establishing common national standards for privacy and security is also critical, as the current patchwork of state laws impedes the sharing of health information. The Health Insurance Portability and Accountability Act (HIPAA) does not pre-empt more restrictive state laws, which create additional barriers to coordinating care. Many of these state laws are historic and inconsistent with current patient care standards and interoperable electronic health systems. We recommend implementing a

single standard of privacy requirement at the federal level to prevent navigating multiple and conflicting regulations.

Promote Integration of Physical and Behavioral Health

Medical professionals recognize the interdependence of physical and behavioral health and the role care coordination has on both quality of care and cost. Trinity Health applauds CMMI and CMS for recently announced models and Medicaid waivers that test integration. The reality is that despite these efforts, most Americans face delays in accessing necessary mental health and substance use care and, when they do receive it, it is in an uncoordinated way. Trinity Health is committed to the integration of behavioral and physical health and through our People-Centered Health System. We have worked hard to provide care seamlessly across patients' needs, including: 1) incorporating behavioral health into payment and delivery models with a population health management focus, 2) promoting collaborative care strategies such as behavioral health integrated within the primary care practice and "warm-handoffs" between behavioral health providers and other members of a patient's primary care team, and 3) leveraging a full array of health care workers, including community health workers, peer-to-peer support specialist, and case managers. The Congress and HHS should continue to promote behavioral and physical health integration.

CMS should incentivize inclusion of behavioral health integration in alternative payment models. Specifically, we recommend CMS provide financial incentives and support, such as up-front care coordination fees to ACOs and flexibility in bundled payments to facilitate integration of behavioral and physical health services as well as wrap-around service delivery and linkage to social supports and services. In addition, aligning quality incentives in APMs across *all payers* will reduce administrative burden and promote seamless care for patients.

The Congress and HHS must also expand the pipeline of behavioral health professionals, and support increased behavioral health training for primary care physicians. First, we recommend provision of adequate reimbursement – from all payers and for all types of care providers – for behavioral health services, increase funding for community-based behavioral health programs and inpatient capacity, and eliminate Medicaid billing restrictions related to mental health services. Congress and HHS should also allow psychiatrists, psychologists, social workers, nurses, care coordinators, community health workers and peer-to-peer support specialists to practice in collaborative, team-based environments according to their highest level of education, training and licensure; and support efforts to facilitate care delivery across states, such as through Licensure Compacts for providers. In addition, telehealth licensing regulations and credentialing should be aligned to allow seamless delivery of telehealth services, including telepsychiatry, across state lines. We also recommend expanding the use of community-based services and in-home care to facilitate transitions across settings; and support community care teams, crisis intervention teams and high-utilizer programs which include wrap-around services for social needs such as housing and food.

Access to Health Care

We will not find success in addressing the cost of health care nor will we reap the maximum benefits of moving toward value-based payment if individuals do not have access to affordable and comprehensive coverage. Trinity Health has worked tirelessly at the state and federal levels to enact the benefits of the Affordable Care Act, especially as they relate to access and coverage for all, because we believe access to health care coverage is basic human right. The Congress and HHS

should work to strengthen, not weaken, policies for access to comprehensive and affordable health care. To this end, we urge Congress to pass legislation that would stabilize the Marketplace, such as reinstating cost-sharing reduction payments.

Need to Advance Meaningful Change

The measures outlined above, particularly initiatives that lead providers to become accountable for outcomes and reducing costs, can significantly improve our health system and the lives of the people we serve. However, they are not sufficient to address fundamental issues that underlie the financing and delivery of care. For commercially insured individuals, high costs resulting from many factors are forcing people with large deductibles and copays to make choices between getting the care they need or food for their families. A system that pushes families into bankruptcy, while requiring others to hold fundraisers in order to obtain needed treatment for their children, does not respect the dignity of every human being. Commercial payers and providers are locked into escalating battles around underpayment, appropriate coding, claim denials, and appropriate care determinations that create administrative waste, burnout among clinicians, and distort the appropriate delivery of care. Variation in payment rules, quality measurement systems and reporting requirements accentuate this administrative waste. We have created a massive financing/administrative superstructure on top of the delivery of care that consumes almost 30% of health care expenditures and may actually be diminishing our ability to deliver excellent care. It certainly distracts us from addressing critical drivers of health in America, such as the opioid epidemic which has led for the first time to an actual decrease in life expectancy for Americans.

Congress has a chance to move toward person-centered care and ensure better health and lower costs. We believe that it is time for leaders to confront some of these fundamental realities and think more broadly about alternative approaches that simplify the financing and administrative dimensions of our health care system and support providers to accept accountability for improving health. Therefore, we recommend the Senate HELP Committee convene hearings with the expressed purpose of understanding the current impact of these issues and considering more fundamental change in these dimensions of our health care system. We would be happy to participate in any way that could be helpful in that effort.

Thank you for the opportunity to respond to this RFI. We hope our comments demonstrate how deeply Trinity Health shares your commitment to reducing health care costs and improving the health and outcomes of patients. If you have questions on our comments, please feel free to contact Tina Weatherwax Grant, JD, Vice President, Public Policy and Advocacy at granttw@trinity-health.org or 734-343-1375.

Sincerely,



Richard J. Gilfillan, M.D.
Chief Executive Officer
Trinity Health