



July 27, 2018

The Honorable Mike Kelly  
Co-Chair, Health Care Innovation Caucus  
U.S. House of Representatives  
1707 Longworth House Office Building  
Washington, DC 20515

The Honorable Ron Kind  
Co-Chair, Health Care Innovation Caucus  
U.S. House of Representatives  
1502 Longworth House Office Building  
Washington, DC 20515

The Honorable Markwayne Mullin  
Co-Chair, Health Care Innovation Caucus  
U.S. House of Representatives  
1113 Longworth House Office Building  
Washington, DC 20515

The Honorable Ami Bera  
Co-Chair, Health Care Innovation Caucus  
U.S. House of Representatives  
1431 Longworth House Office Building  
Washington, DC 20515

RE: Congressional Health Care Innovation Caucus Request for Information (RFI)

Submitted electronically via email to: [InnovationCaucus@mail.house.gov](mailto:InnovationCaucus@mail.house.gov)

Dear Health Care Innovation Caucus Co-Chairs:

Trinity Health appreciates the opportunity to offer recommendations on how best to accelerate health care transformation towards a system that rewards value and outcomes. Our comments 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. As the Health Care Innovation Caucus sets its agenda and priorities, our comments reflect those policy opportunities that we believe are most critical, particularly to advancing these policy opportunities with the Centers for Medicare and Medicaid Services (CMS).

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 1.4 million lives across the country through alternative payment models (APMs).

## **Value-Based Arrangements and Provider Payment Reform**

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. The Trinity Health Board of Directors have approved our system-wide strategy to "Build a People Centered Health System" that would be accountable for delivering better health, better care and lower costs for the communities we serve. Our People-Centered 2020 Plan includes initiatives to transform the way we deliver care and the ways we are reimbursed. One of our goals is to have 75 percent of our revenue flowing through APMs by 2020. Towards this end, Trinity Health is currently participating in 16 markets with Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs) and has five markets partnering as a Next Generation ACO. In addition, we have 33 hospitals participating in the Model 2 Bundled Payments for Care Improvement (BPCI) initiative, 11 Skilled Nursing Facilities (SNFs) in Model 3 BPCI, and two 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 101 non-CMS APM contracts. **Trinity Health is currently accountable—through our APMs—for \$8.6 billion in total cost of care for almost 1.4 million people, and we have over \$50 million of risk performance. We have invested almost \$120 million in APMs, which has generated significant shared savings. But, we are not at breakeven, rather are operating at a net loss of about \$18 million. 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 that the Center for Medicare and Medicaid Innovation (CMMI) at CMS holds great promise in promoting transparent model design across all payers; supporting evaluation and measurement of model impacts; and developing market-based innovations that build on promising practices. Trinity Health has urged CMS to continue to evolve existing models and programs that drive value-based care, promote population health and engage beneficiaries. CMMI has been a leader in this work, but significant difficulties exist with data, systems and policy changes.**

### ***Financially Rewarding and Sustainable Models Are Imperatives***

Providers are hungry for programmatic changes that will offer a more promising, predictable and sustainable value opportunity for well-executed programs. Recognizing that delivery transformation represents the best long-term solution to reducing the financial burdens of the Medicare and Medicaid programs, CMS should adopt a long-term strategic approach that entices as many providers as possible to participate and invest. **Policymakers should take a strategic approach that lays out an attractive, 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, 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 this strategic approach.**

Health care providers, hospitals, physicians and others are facing 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. Currently, many providers view APMs as having insufficient opportunity. They are hesitant to take on downside risk exposure because of the negative prior experience with similar models in the 1990's and the significant losses that providers experienced in total cost of care contracts. Additionally, many physician organizations

simply do not have the cash reserves needed to sustain themselves through a negative experience. 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. Most APMs do not include prospective or even concurrent payments to cover these investments. **Thus, 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 effectively 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 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 attractive, predictable and rewarding from inception. CMS can look for some of the 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 no downside financial risk for up to three years.** After 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.

**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 to impact 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.

**Better 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 management and medical management of a population within a high-performing network. **The flexibility to provide alternative sites of services (i.e. care in the home) and care management capability in Medicare Advantage should be transcended 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, rather than driving providers out of ACOs into Medicare Advantage. It would, as a result, help to reduce Medicare spending as well.

**Eliminate rebasing and move toward trended, market-based benchmark targets.** Trinity Health has recommended against a "one-size fits all" approach to benchmarking and rebasing given the variations in local market conditions and provider experience in moving to risk-sharing. We recommend that rebasing is eliminated and replaced with market-based targets.

**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. Trinity Health has demonstrated successfully that ACOs are a viable alternative to fee-for-service and Medicare Advantage. We 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 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 is very interested in ensuring such a convening occurs.**

**Improve attribution rules and allow members to self-select into the ACO at any time.** Trinity Health encourages expanded testing of prospective beneficiary assignment, which increases provider transparency and accountability for patient care and their own performance. Prospective assignment would increase certainty for the ACO and help minimize unexpected changes in its benchmark.

**Make all waivers available to all ACOs, regardless of downside risk.** Trinity Health urges expanded eligibility for Medicare waivers in a manner that is not prohibitively burdensome to ACOs that utilize them. Waiving certain payment regulations is essential so that these models can effectively coordinate care and ensure that it is provided in the right place at the right time. This includes SNF 3-day waivers and waivers to rules limiting post-acute care payment. In addition, Trinity Health urges CMS to make additional waivers available including those related to site of care, telehealth, hospital discharge planning requirements, homebound requirements for home health, and Medicare primary care 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.** Trinity Health believes that 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. The industry needs to rapidly adopt existing consensus-driven core measure sets while working to identify the next

generation of core measures. Trinity Health believes it is critical that the industry advance and adopt patient-reported outcomes measures or PROMs.

**Incorporate social determinants of health into new delivery and payment models.** Trinity Health is committed to advancing the health of individuals and populations. We strongly believe that new payment and delivery models—as well as existing ones—should support addressing the social determinants of health, which research has shown to be related to health outcomes, while also reducing costs. As new models are tested, this is an area where CMS can continue to work with state, regional and local stakeholders to find innovative ways to integrate social services into care management programs and to foster payment models that support such integration. This should also include adjustment to payment based upon sociodemographic factors.

### **Technology and HIT**

Interoperability is a key strategic imperative for Trinity Health. We believe that interoperability is essential to a high-performing People-Centered Health System because it allows the widespread exchange of structured and standardized health information through interoperable health information technology (health IT). **Health IT makes it more simple to place the patient at the center of an interconnected system of his/her own medical data and 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 steps 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 remains conspicuously absent. Consistency in patient matching is also essential to patient safety and to ensuring that the information in a patient's EMR actually belongs to that patient and includes all available information.

**Establishing common national standards for privacy and security is also critical.** This will improve the appropriate and secure flow of health data. The current patchwork of state laws impedes information flow.

Trinity Health is committed to working across the health care continuum to advance interoperability and to help consumers easily and securely access their electronic health data, direct it to any desired location, and be assured that their health information will be effectively and safely used to benefit their health and the health of their community. As Trinity Health works toward a People-Centered Health System, we are also working to provide appropriate opportunities for patients to capture, use and share their health data electronically with providers through the use of personal health devices, personal health tracking tools and more traditional medical devices for remote monitoring. This is part of our commitment to putting the people we serve at the center of every behavior, action and decision.

Thank you for the opportunity to respond to this RFI. We hope our comments demonstrate how deeply Trinity Health shares your commitment to transforming the health care delivery system into one that pays for value. Trinity Health is also a founding member of The Health Care Transformation Task Force (“HCTTF” or “Task Force”) and supports their comments and recommendations as well.

**We look forward to working with the Health Care Innovation Caucus and would very much welcome the opportunity to meet with you to further share our experiences and innovative policy ideas.** If you have any questions on our comments, please feel free to contact Tina Weatherwax Grant, JD, Vice President, Public Policy and Advocacy, at [granttw@trinity-health.org](mailto:granttw@trinity-health.org) or 734-343-1375.

Sincerely,

A handwritten signature in black ink that reads "Richard J. Gilfillan M.D." with a stylized flourish at the end.

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