

June 29, 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: CMS– 2442–P; Medicaid Program; Ensuring Access to Medicaid Services

Submitted electronically via <http://www.regulations.gov>

Dear Administrator Brooks-LaSure,

Trinity Health appreciates the opportunity to comment on policies set forth in CMS-2442–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, especially among vulnerable populations such as those covered by Medicaid.

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 is committed to serving as a critical provider in our communities and coordinating care across settings and the care continuum, with 41% of our revenue coming from Medicare and 18% from Medicaid and uninsured patients.

Trinity Health is also a strong proponent of value-based care delivery. We have 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 11 markets partnering in one national MSSP Enhanced Track ACO—Trinity Health Integrated Care. All of these markets participate 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 participated 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. We have 1 million lives in commercial and Medicaid alternative payment models and we seek more contracts with Medicaid where we have accountability for cost and care, like the value-based agreements we hold in Idaho, Oregon and Massachusetts.

Further, as the largest not-for-profit provider of Programs of All-inclusive Care for the Elderly (PACE), our experience in caring for the Medicare/Medicaid, dually eligible population is considerable and positive as 94% of our PACE participants are dually enrolled. To qualify for PACE, a person must be age 55 or over, live in a PACE service area, and be certified by the state to need a nursing home level care. Trinity Health PACE currently has 13 programs and 19 centers (owned or managed) in 9 states with 3 more currently under development. Access and growth of PACE remains a high priority for Trinity Health.

Driven by the belief that everyone should have access to health care coverage, Trinity Health views Medicaid coverage as key to making people-centered care possible. We recognize the importance of the Medicaid program and work to deliver high-quality, accessible, equitable care to the Medicaid beneficiaries we serve regardless of whether they receive benefits through fee for service or managed care.

Trinity Health supports many of the goals CMS aims to address in the “Medicaid Program; Ensuring Access to Medicaid Services” notice of proposed rulemaking. In general, Trinity Support’s CMS’ aim to :

- Advance access to care and essential services among Medicaid beneficiaries
- Encourage beneficiary and other stakeholder engagement
- Align standards and processes across programs and delivery systems, to the extent feasible and appropriate
- Advance policies that strengthen access to home and community based services
- Strengthen the healthcare workforce

Below, we offer our detailed comments on select provisions, organized by section of the rule.

A. Medicaid Advisory Committee and Beneficiary Advisory Group

The Center for Medicare and Medicaid Services (CMS) proposes a number of changes to the Medical Care Advisory Committee (MCAC) including: renaming them to Medicaid Advisory Committees (MAC); expanding their scope to include advising states on policy development and effective program administration in addition to health and medical care services; and specifying stakeholder engagement. Specifically, with respect to stakeholder representation on the MAC, CMS proposes to establish minimum requirements—including representation from the Beneficiary Advisory Group (BAG) and other interested parties (e.g., consumer advocacy groups or community-based organizations, clinical providers or administrators, Medicaid managed care plans, and other state agencies serving Medicaid beneficiaries).

Trinity Health strongly recommends that CMS include hospital and safety net provider representatives in the list of interested parties that should/must be included in the MAC. Specifically, the list should include—at a minimum—safety net providers that include hospitals, primary care providers and maternity care providers. It is essential to ensure the voice of safety-net providers serving the Medicaid population is represented on the MAC and that these providers have the opportunity to use their first-hand, front-line experience to inform policy, program administration and health and medical services. These providers understand the health and social needs of the

Medicaid beneficiaries they serve and can advise the Medicaid program on policy development and implementation.

B. Home and Community-Based Services (HCBS)

Incident Management System /Reporting

CMS proposes to require that states operate and maintain an incident management system that allows state programs to identify and address critical incidence of abuse, neglect, exploitation, and harm in the delivery of HCBS across FFS and managed care. CMS proposes establishing a minimum definition of “critical incident” and minimum state performance and reporting requirements for investigation and action related to critical incidents. Providers would be required to report on critical incidence related to person-centered service plans or failure to provide authorized services.

Trinity Health supports CMS’ goal of ensuring that potentially harmful, critical incidents in delivery of HCBS are identified and addressed. We recommend that as CMS establishes requirements for state incident management systems, that the Agency work with states to make clear the responsibilities of organizations that may be subcontracting with providers or community-based organizations whose actions may lead to a “critical incidence”.

Trinity Health has unfortunately had several experiences in subcontracting with community-based organizations that may have acted in a way that resulted in what would appear to meet CMS’ proposed definition of a “critical incidence” (e.g., financial exploitation as a result of fraudulent billing). We have acted quickly to address these issues as soon as they have been identified. Our goal is always to support high-quality, accessible care and avoid critical incidence that may pose harm to beneficiaries. However, there are certain circumstances where subcontractors may act in inappropriate ways and providers should not always be held responsible. We recommend CMS consider such sub-contractual circumstances as it works to finalize proposed policies. Specifically, we urge CMS to request state agencies ensure that the correct entity is both subject to the proposed investigation around a critical incident and responsible for implementing corrective actions.

HCBS Payment Adequacy / Reporting

To help address direct care workforce shortages, CMS proposes to require that at least 80% of all state Medicaid MCO and FFS payments for homemaker services, home health aide services, and personal care services be spent on compensation to direct care workers. CMS also proposes to require states to annually report on the percent of payments for homemaker, home health aide, and personal care services that are spent on compensation for direct care workers. To support stakeholders’ awareness of how Medicaid payment rates for these services are established, CMS proposes to require states to publish—every other year—the average hourly rate paid to direct care workers delivering personal care, home health aide, and homemaker services.

The National Association of Home Care (NAHC) is currently performing a national survey of members to solicit feedback on payment for the direct care workforce. We recommend that CMS wait for the results of this survey before it moves forward with finalizing requirements related to the minimum percentage of a state’s Medicaid payments that should be spent on compensation for

certain direct care workers. We support using the proposed definition of compensation—which includes salary, wages, and benefits (e.g., health and dental benefits, sick leave, and tuition reimbursement); however, we also recommend that unemployment insurance be factored into benefits. We believe 80% is too high if CMS were to take into account all benefits and high administrative burden. Additionally, we urge CMS to consider the administrative burden that this proposal may place on state agencies working to implement this policy, especially as it aims to reduce funds available for administration. Finally, we do not recommend this policy apply to all 1915 waiver authorities.

C. Documentation of Access to Care and Service Payment Rates

Fully Fee-For-Service States

In the Medicaid Program; Medicaid and Children’s Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality proposed rule, CMS proposes timeliness standards related to appointment wait times, secret shopper survey requirements, and publication requirements related to adult and pediatric outpatient mental health and substance use disorder, adult and pediatric primary care services, obstetrics and gynecology services and any additional type of service determined by the state. In this rule, CMS seeks comment on applying these standards to states with a fully FFS delivery system and if additional access standards are needed for these states.

Trinity Health supports CMS’ aim to establish additional standards that will increase access to Medicaid services for those in states with fully FFS-based delivery systems. We generally support alignment of standards across delivery systems and programs—where appropriate—as this allows comparable standards for patients transitioning between coverage types as well as the providers that serve them. We also support standardization across qualified health plans, Medicaid managed care, Medicaid FFS and care delivered through value-based arrangements—to the extent feasible. Alignment may lessen administrative burden for providers, payers, and other stakeholders while improving outcomes for Medicaid beneficiaries.

Payment Rate Transparency - Publication of FFS Payment Rates

CMS proposes to require that states publish and regularly update Medicaid FFS payment rates for all Medicaid services. This information would be available on a website that is accessible and easy for the public to use. For select services, a state would be required to conduct a comparative analysis of the state’s Medicaid payment rates and Medicare payment rates and disclose certain HCBS payment rates—personal care services, home health aide services, and homemaker services. If payment rates vary by certain factors (e.g., pediatric vs. adult population, provider type, geographic location) the state must separately publish these rates.

Trinity Health supports CMS’ intent to ensure that Medicaid FFS payment rates are public and easily accessible with the goal of promoting payment transparency for patients, providers and policymakers. We believe that making this information publicly available will offer additional insight around sufficiency of rates and help identify potential access issues, which is particularly important for safety-net providers and the patients they serve.

Payment Rate Transparency - Categories of Services of Comparative Rate Analysis and Disclosure

No less than every two years, CMS proposes to require states to publish an analysis that compares Medicaid FFS and Medicare payment rates for the following critical services: primary care services, obstetrical and gynecological services, and outpatient behavioral health. Additionally, no less than every two years, states would also be required to publicly disclose FFS HCBS payment rates for the following services: personal care services, home health aide services, and homemaker services. State disclosure of Medicaid FFS HCBS payment rates would include average hourly payment rates, claims volume, and the number of Medicaid enrolled beneficiaries who received those services.

Trinity Health appreciates CMS' request for comment on its proposal not to include inpatient behavioral health services in the list of services included in the payment rate disclosure and comparative rate analysis requirements. We believe that there are significant access issues to inpatient behavioral health services and recommend CMS reconsider including inpatient behavioral health services in this proposal. We believe this would help identify challenges with access to inpatient behavioral health services and support steps to expand access to needed care.

Payment Rate Transparency - Required Content of FFS Comparative Payment Rate Analysis and HCBS Payment Rate Disclosure

CMS proposes that the comparative rate analysis would compare the state's Medicaid FFS payment rates to the most recently published Medicare payment rates, using the non-facility payment rates as listed in the Medicare Physician Fee Schedule as a benchmark. CMS notes that the codes would be listed in sub regulatory guidance and indicates what selection criteria it will use. For the HCBS payment rate disclosure, states would need to quantify the number of Medicaid-paid claims and the number of Medicaid enrolled beneficiaries who received a service within a calendar year organized by the service.

Trinity Health supports CMS' proposal to use the Medicare non-facility payment rates as a benchmark for the rate analysis.

Payment Rate Transparency - Medicaid Payment Rate Interested Parties' Advisory Group.

CMS proposes to require states to establish an advisory group of interested parties to advise and consult on FFS rates (regardless of whether they are under the state plan or a waiver) that are paid to direct care workers providing HCBS for personal care, home health aide, homemaker services, and any other services states choose for the advisory group to focus on. The advisory group would be required to include direct care workers, beneficiaries and their authorized representatives and other interested parties. It would advise and consult on current and proposed HCBS payment rates, payment adequacy data, and access to care metrics for personal care, home health aide and homemaker services, though states would not be required to adopt recommendations. Additionally, CMS proposes that the process used by the state to select members and convene its meetings must be made publicly available. Recommendations must also be made publicly available.

Health care workforce stability is one of Trinity Health's policy priorities. We advocate for programs that address health workforce shortages across the care delivery continuum and support policies to develop a healthy and stable workforce. Trinity Health appreciates CMS'

proposal to create a state-level advisory group focused on the direct care workforce. In addition to the stakeholders that CMS has identified for inclusion in the work group, we strongly recommend that CMS include hospital and safety net provider representatives on the list of interested parties that should/must be included. It is essential to ensure safety-net providers serving the Medicaid population have the opportunity to participate given their understanding of the health and social needs and access challenges faced by the beneficiaries they care for. However, we also recommend that groups that have a conflict of interest be prohibited from participating in these advisory groups.

State Analysis Procedures for Rate Reduction or Restructuring

CMS proposes changes to its system for assessing if state plan amendments designed to reduce or restructure provider payment would also reduce access to services. Specifically, CMS proposes that states would be required to demonstrate that any SPA to reduce provider payment rates or to restructure provider payments will not put access to care at risk. CMS proposes a two-tiered analysis system, which would require states to provide a more extensive access analysis if certain conditions are not met.

Trinity Health supports CMS' proposed approach for reviewing SPAs that include rate reductions or restructuring. In particular, we appreciate that CMS will work to ensure the outlined criteria are met and, if they are not, CMS will do a more extensive analysis of the state's proposal.

Conclusion

Trinity appreciates this opportunity to comment on the Medicaid Program; Ensuring Access to Medicaid Services notice of proposed rulemaking. We welcome the opportunity to serve as a resource on these issues. Please feel free to contact Jen Nading with any questions at jennifer.nading@trinity-health.org

Sincerely,

/s/

Jennifer Nading

Director, Medicare and Medicaid Policy and Regulatory Affairs

Trinity Health