Trinity Health

September 4, 2024

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-1809-P; Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs, including the Hospital Inpatient Quality Reporting Program; Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals; Prior Authorization; Requests for Information; Medicaid and CHIP Continuous Eligibility; Medicaid Clinic Services Four Walls Exceptions; Individuals Currently or Formerly in Custody of Penal Authorities; Revision to Medicare Special Enrollment Period for Formerly Incarcerated Individuals; and All-Inclusive Rate Add-On Payment for High-Cost Drugs Provided by Indian Health Service and Tribal Facilities

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

Dear Administrator Brooks-LaSure,

Trinity Health appreciates the opportunity to comment on policies set forth in CMS-1809-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 121,000 colleagues and more than 26,000 physicians and clinicians caring for diverse communities across 27 states. Nationally recognized for care and experience, the Trinity Health system includes 101 hospitals, 126 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 8,200 medical group physicians and providers. Based in Livonia, Michigan, its annual operating revenue is $21.6 billion with $1.5 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 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 participated for many years 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.

In our comments below, Trinity Health urges CMS to:

- Use its special exceptions and adjustment authority to make a one-time retrospective adjustment of 10-15% to the market basket to account for what hospitals should have received in 2022 when accounting for inflation.
- Establish a threshold whereby if the payment differential between what was provided and actual costs is greater than 1.5 percentage points, CMS would retroactively adjust payments for that year.
- Work with Congress to permanently extend telehealth flexibilities by year end and reinstate the ability be reimbursed for the originating site facility fee (Q3014) or an equivalent code.
- Include one additional year of voluntary reporting for the new health equity and Information Transfer PRO-PM measures with mandatory reporting in CY2027.
- Make the period of July 2024-June 2025 mandatory without penalties for data validation for the Hybrid Hospital-wide All-cause Readmission and Mortality Measures.

Payment Update for OPPS and ASC

Given the extraordinary inflationary environment and continued labor and supply cost pressures hospitals face, Trinity Health is deeply concerned with the proposed payment increase of 2.6% in the FY25 OPPS rule. This update is woefully inadequate and does not reflect the unprecedented increase in the cost of caring for patients and comes at a time when many non-profit health systems are struggling to stay afloat after years of COVID-related financial losses, high inflation, and increased labor expenditures. **We urge CMS to provide fair payment and increase payment rates to reflect the increased cost of caring for patients. Specifically, CMS should:**

- **Use its special exceptions and adjustment authority to make a one-time retrospective adjustment of 10-15% to the market basket to account for what hospitals should have received in 2022 when accounting for inflation.**
- **Establish a threshold whereby if the payment differential between what was provided and actual costs is greater than 1.5 percentage points, CMS would retroactively adjust payments for that year.**
- **Rebase the market baskets more frequently and at least every three years to ensure the market basket reflects the appropriate mix of services provided to Medicare beneficiaries.**

The cost of caring for patients in recent years has been significantly higher than the increase reflected in the Medicare annual payment updates. Since 2020, Medicare rates have increased 6% while Trinity Health's cost per case has increased 10% including:

- 10% increase in labor costs.
- 17% increase in supply costs.
- 20% increase in drug costs.
- 15% increase in implant costs

This inflation has made it harder for hospitals to maintain access to care and invest in cybersecurity and cutting-edge treatment. To maintain access to quality care for Medicare beneficiaries, reimbursement must cover the cost of delivering care. At Trinity Health, 49% of revenue comes from Medicare. Unfortunately, Medicare payment rates have not kept up with the increased costs of delivering care across all settings. With 20% of our

revenue also coming from Medicaid and patients who are uninsured, there is little room to cost-shift Medicare losses to other payers.

Telehealth

The telehealth flexibilities provided since the COVID-19 pandemic have greatly benefited patients, caregivers, and providers. Telehealth must become a routine part of patient care to maintain access and meet consumer expectations for convenient, person-centered, technology-supported care. Trinity Health is committed to ensuring that all patients have the ability to use telehealth services when needed, including the most disadvantaged. We urge CMS to work with Congress to implement policy changes that support the permanent continuation of telehealth flexibilities to enable an efficient and equitable health care system.

Trinity Health urges CMS and Congress work together to *permanently* extend telehealth flexibilities by year end, including:

- Allow all telehealth visits to be reimbursed when originated within the patient's home or location of their choosing.
- Allow all Medicare patients access to telehealth, regardless of geographic location.
- Allow clinicians to furnish and bill with parity of payment for in-office visits across all payers and settings.
- Ensure audio-only remains a reimbursable option for physicians to care for patients who do not have audio and visual technology or capability.
- Allow coverage of the facility component of telehealth offered in a provider-based clinic.
- Reimburse providers for telehealth services in home health benefits.
- Include attribution to an ACO as evidence of an existing provider/patient relationship.
- Maintain flexibility for remote-patient monitoring and reimburse for this service, including when provided through home health.
- Allow clinicians to be reimbursed for telehealth when seeing new patients or a patient not previously seen at their practice.
- Remove limitations on frequency of services.
- Advance policies that ensure access to affordable broadband, technology resources, and telehealth services for communities of color and other underserved populations.
- Allow providers to practice across states lines and at the top of their license, including medication prescription and flexibility to allow physicians to treat their patients while in a state where they may be temporarily located.

In addition, we urge CMS to reinstate the ability be reimbursed for the originating site facility fee (Q3014) or an equivalent code.

Virtual Direct Supervision

In CY 2024, CMS extended virtual supervision flexibilities for cardiac rehabilitation services, intensive cardiac rehabilitation services, pulmonary rehabilitations services, and diagnostic services furnished in accordance with Consolidated Appropriations Act of 2023. Specifically, CMS allowed direct supervision to be furnished via two-way, audio/visual communication technology (excluding audio only) for these services. In the proposed rule, CMS proposes to extend virtual supervision flexibilities for OPPS through Dec. 31, 2025.

Trinity Health supports this proposal.

Quality Measures

Health Equity Measures

The rule would adopt three new measures related to health equity for the outpatient, ASC and rural emergency hospital quality reporting programs. Specifically, CMS proposes (1) a Hospital Commitment to Health Equity Measure, (2) a Screening for Social Drivers of Health Measure, and (3) a Screen Positive Rate for Social Drivers of Health Measure.

Trinity Health supports adding these measures to OPPS; however, we are concerned with the timeline for implementation. While the initial requirement is for attestation, mandatory reporting will be required for CY2026. **Given the time it took for us to get these measures implemented with EHR vendors for the Inpatient Quality Reporting Program, we urge CMS to include one additional year of voluntary reporting with mandatory reporting in CY2027.**

In addition, we urge CMS to work with stakeholders to finetune its portfolio of health-equity related measures. CMS should prioritize adopting a streamlined measure set that is consistent across settings and that provides meaningful and actionable data aimed at addressing social determinants of health and advancing health equity.

Information Transfer PRO-PM

The rule would adopt a patient-reported outcome measure (PRO-PM) beginning with voluntary reporting in CY 2026 and mandatory reporting in CY 2027. The measure would report the average score of a patient's ratings on a three-domain, nine-item post-operative survey regarding the clarity of clinical information given before, during and after an outpatient surgery or procedure.

Hospitals have only just started to report PRO-PMs for the total hips and knees measure and it has taken a significant amount of time and resources for our teams and our EHR vendors. **Given the complexity, resources that would be required for the roll out of this measure, and the amount of updates required for EHRs, we urge CMS to provide one additional year of voluntary reporting with mandatory reporting being pushed out to CY2028.**

Proposed Modification of the Hybrid Hospital-wide All-cause Readmission and Mortality Measures in the IQR

In previous rulemaking, CMS adopted a measure for the Inpatient Quality Reporting Program that uses claims data and core clinical data elements and linking variables derived from EHRs for risk adjustment. Based on performance during the most recent voluntary reporting period, about three-quarters of hospitals that chose to report these measures (about one-third of all inpatient PPS hospitals) would not have met the reporting thresholds and hospitals have shared with CMS various issues they have had with reporting this information. As a result, CMS proposes extending the voluntary reporting period for an additional year.

Trinity Health applauds CMS for listening to stakeholders and extending this voluntary reporting period. In addition, we urge CMS to make the following year (7/1/24-6/30/25) mandatory without penalties for data validation as there are issues with adequate CMS report feedback to correct data accuracy problems.

Proposed Public Reporting of Median Time from ED Arrival to ED Departure for Discharged ED Patients — Psychiatric/Mental Health Patients Strata

In prior rules, CMS adopted a policy in which they publicly report three out of four separately calculated rates for the measure of throughput time and these measures are displayed publicly on Care Compare. The fourth rate,

which includes ED throughput time for patients seeking care for psychiatric or mental health concerns, is calculated and available for download but not currently displayed on Care Compare. CMS proposes to make this data available on Care Compare beginning CY 2025 to provide information on ED throughput for patients seeking care for behavioral health concerns.

Depending on their needs, a patient can remain in the ED for hours or days until it is determined safe for them to be released or until they can be admitted into an inpatient psychiatric facility. Thus, ED throughput times can look long and may deter someone from seeking care. **We are concerned publishing this information to Care Compare could disincentivize someone from seeking necessary care and therefore we do not recommend CMS finalize this proposal.**

CONCLUSION

We welcome the opportunity to inform any future policy and are happy to partner with CMS. 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