Trinity Health
Senior Communities

May 24, 2024

Chiquita Brooks-LaSure Administrator
Center for Medicare and Medicaid Services Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Subject: **(CMS-1802-P)** Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2025.

Electronically via: http://www.regulations.gov

Dear Administrator Brooks-LaSure,

Trinity Health Senior Communities (THSC), a National Health Ministry of Trinity Health, is a faith-based organization that serves more than 730 residents in its owned skilled nursing communities across five states: Connecticut, Indiana, Iowa, Michigan, and North Carolina. These residents receive long term care, memory care, rehabilitative therapy, and other skilled services from colleagues whose focus is clinical excellence and compassionate care. Trinity Health Senior Communities collaborates under management contracts with six additional older adult communities in four states to serve another 200+ residents in need of skilled nursing services. We appreciate the opportunity to comment on (CMS-1802-P) Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2025.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, faith-based health care systems in the nation. It is a family of 121,000 colleagues and nearly 36,500 physicians and clinicians caring for diverse communities across twenty-seven 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. In fiscal year 2023, the Livonia, Michigan-based health system invested $1.5 billion in its communities in the form of charity care and other community benefit programs.

Our comments on the proposed rules for Skilled Nursing Facilities (SNFs) are provided with a sense of impending crisis as the final staffing rule would significantly impact our ability to remain financially sustainable and continue to serve the most vulnerable patient populations. Any payment update should be reflective of this final rule.

The population is aging, and more people have chronic conditions that will ultimately require care. The cost to deliver this care will grow. Nursing Homes must remain a viable option for those in need of long-term care.

Our Comments are as follows:

2025 Proposed Payment Updates: While THSC applauds the proposed payment increase of 4.1%, it fails to cover the increased cost of care in the current healthcare environment due to staffing shortages, inflation, and regulatory mandates such as the Enhanced Barrier Protections (EBP) which requires additional instances of gowning and gloving in the treatment of resident standards for preventing transmission of multidrug-resistant organisms in nursing homes. Our estimate is that this new rule alone will have an annual $700,000 expense. Furthermore, the proposed increase does not

assist facilities as they work toward meeting the final staffing rule. These policies and the current workforce and inflationary environment will result in increases in costs for caring for residents, including those admitted to nursing homes for a Part A-covered stay. Our estimated increase in payroll expenses without accounting for the final staffing rule is 4.2% while inflation on supplies is hovering around 4%.

THSC expressed our concerns in our comments to CMS about what the additional cost would be to cover just the baseline of additional staffing to meet the standards of the new rule. By conservative estimates, THSC is looking at an annual increase in payroll of over $8.9 million. This does not consider what wages will likely be when this rule is completely implemented. We are certain that initial estimate will be higher in two years. Meeting the current and new challenges will require much more than a 4.1% Medicare increase. In summary, reimbursement to cover the cost of the new staffing rule and the current market environment is significantly insufficient. **As states are unlikely to increase Medicaid rates to meet the new required standards that CMS has put forth, Medicare SNF rates would need to increase by 10% to adequately sustain the industry. THSC asks CMS to increase the SNF payment rate to be reflective of the current regulatory, workforce, and inflationary environment.**

Wage Index Updates: CMS proposes to update to the wage index based on 2020 census data. CMS continues to use the hospital inpatient wage index data, exclusive of the occupational mix adjustment, citing a lack of SNF-specific wage index data. CMS states that development of a SNF-specific wage index is infeasible due to "the volatility of existing SNF wage data and the significant number of resources that would be required to improve the quality of the data," such as auditing SNF cost reports.

CMS's proposed update to the wage index would incorporate revised delineations of Core-Based Statistical Areas (CBSAs) to reflect actual costs of labor more accurately in each area. CMS notes that the new delineations include changes such as splitting of CBSAs, creation of new CBSAs, and changes to rural and urban classification of counties. CMS will continue to use existing methodology of averaging CBSAs to calculate wage index for geographic areas in which there are no hospitals and therefore no hospital wage index data. CMS will also apply the policy finalized in FY 2023 that caps a SNF's wage index reductions each year at 5% to mitigate negative financial impacts caused by adopting new delineations and to provide stability in year-to-year wage index variations.

However, the revised CBSA delineations using counties and county equivalents causes significant changes and there has not been sufficient time (approx. 8 months between bulletins being issued and proposed rule being published) to study the impact of these changes. Urban areas will change to Rural, Rural to Urban and CBSAs will split and/or merge causing a considerable number of changes. No transition period is proposed as has been used in the past due to a permanent 5% cap on reductions in the wage index. Based on the proposed rule, Moore County in North Carolina is changing from Rural to Urban resulting in the wage index going down over 5% which is well below the proposed Rural wage index. West Hartford County in Connecticut CBSA is subject to a name change in addition to Connecticut moving from CBSAs to Planning Regions resulting in the wage index decreasing just under the 5% cap. **Therefore, THSC is requesting a one-year transition period.**

Consolidated Billing: CMS requests comments identifying Healthcare Common Procedure Coding System (HCPCS) codes that should be excluded from consolidated billing. THSC believes that CMS should expand the five categories of high-cost and low probability HCPCS codes by adding HPSC codes or amend the HCPCS codes to include high-cost medications such as Glucagon-like Peptide 1 (GPL-1) medications, new Tardive Dyskinesia (TD) medications and Ocular Injections. These and others pose a significant, unreimbursed risk for skilled nursing communities and impacts the consumers ability to receive skilled nursing care. Reimbursement rates have not kept pace with the cost of these medications. Individuals on these medications are denied admission to a skilled nursing facility due to the prohibitive cost of these medications and extremely poor reimbursement

rates. These medications and the cost associated with them is already impacting access for some patients.

Patient-Driven Payment Model Updates: CMS proposes technical revisions to the code mappings used to assign patients to clinical categories in the Patient-Driven Payment Model (PDPM) and requests feedback on potential changes to the non-therapy ancillary (NTA) component of PDPM. The industry has already experienced negative modifications with the parity adjustment of the last 2 years – reducing NTA will negate the budget neutrality already achieved. Patients are not less costly to care for. NTA points assist with deferring cost of items not excluded under consolidated billing and high-cost medications for some of the conditions being targeted for reduction. In addition, reducing points for conditions that are commonly admitted to the nursing facilities, while adding points to those conditions that show 0% utilization does not allow facilities to receive payment for conditions that are no less costly, but now worth less points and frequently cared for. For example, adding points for Lung Transplant with no demonstrated utilization while reducing Chronic Obstructive Pulmonary Disease (COPD) points showing 29% utilization seems to punish providers for providing care to residents with a condition with known high recidivism for re-hospitalization. **THSC requests that CMS eliminate further adjustments that would reduce the NTA.**

SNF Quality Reporting Program: CMS proposes changes to the SNF Quality Reporting Program (QRP) to include the addition and modification of standardized patient assessment data elements (SPADEs) and adoption of data validation processes for claims-based and assessment-based measures. CMS also requests feedback on future measure concepts for inclusion in the SNF QRP.

Standardized Patient Assessment Data Elements (SPADEs): CMS proposes the addition of 4 SPADEs and modification of one existing SPADE to be collected on the MDS under the social determinants of health (SDOH) category beginning in FY 2027. CMS states that these data elements will assist providers in addressing disparities that impact underserved communities and improving health equity by identifying social needs to be addressed during discharge planning. THSC supports and commends the additional collection of SPADE data on social determinants of health. This is an important initiative to ensure support for those who experience healthcare disparities and will assist with more appropriate discharge planning. However, **THSC asks that CMS consider an exclusion for those long-stay residents that utilize the Part A Medicare benefit with no plan for discharge.**

Data Validation Processes: CMS is proposing to adopt validation processes for SNF Quality Reporting Program (QRP). The data validation process places an undue burden on nursing homes. QRP and Value Based Purchasing (VBP) use different reporting and baseline periods. This makes it difficult to use the same assessment/claim periods.

The proposed audit process will put an undue burden on nursing home staff and impact the ability to operate effectively. The continued addition of validation audits is not effective in improving services to those in our care. Furthermore, failure to submit for any reason results in a 2% reduction to the market basket in the second fiscal year out. This is in addition to the standard 2% reduction for the VBP program and sequestration which is burdensome and fiscally unsustainable.

Request for Information: CMS includes a Request for Information on future measure concepts under consideration for SNF QRP. CMS has identified four measure concepts, one being a pain management composite and a second a vaccine composite. THSC is opposed to the pain management and vaccine component for future QRP. CMS has eliminated the pain quality measure due to the problem of opioid addiction. An unprecedented rise in the number of deaths from overdose in the past two decades is associated with prescription opioids, heroin, and synthetic opioids.[1]

1) (Ahmad F, Rossen L, Spencer M, Warner M, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. https://www.cdc.gov/nchs/ nvss/vsrr/drug-overdose-data.htm. Published 2018).

In a CMS Quality Safety Oversite Letter dated October of 2019, CMS directed, "Removal of quality measures related to pain." In March 2019, CMS released the CMS Roadmap for Fighting the Opioid Crisis. One aspect of this roadmap is a directive to address how quality measures may provide incentives for inappropriate opioid prescribing. We believe facilities have taken strong actions to prevent the overuse of opioids. However, due to the severity of the Opioid Crisis, we want to avoid any potential scenario where a facility's performance on the pain quality measures may inappropriately contribute to their decision to seek the administration of an opioid. To support this, CMS will be removing two quality measures from the Nursing Home Compare website and the Five Star Quality Rating System in October 2019. These measures are: • Percentage of short-stay residents who report moderate to severe pain. • Percentage of long-stay residents who report moderate to severe pain."[2] Therefore, **THSC does not support the pain management composite as a future measure under SNF QRP.**

Residents of nursing facilities have long had the ability to choose whether to receive a vaccine. Consumers should continue to be allowed to make personal decisions regarding their own health, including vaccines. Nursing home providers should not be held accountable for the personal choices patients make. There is no benefit to reporting this data, therefore, **THSC does not support the vaccine composite under SNF QRP**.

Nursing Home Enforcement: CMS proposes changes to nursing home enforcement beginning in FY 2025 that would expand CMS's authority related to civil money penalties (CMPs). Currently surveyors can impose per day (PD) OR per instance (PI) CMPs totaling $10,000/day, annually adjusted by inflation. The proposed rule would allow PD and PI CMPs to be imposed jointly and multiple times. CMS states that this would ensure that compliance is quickly achieved and is lasting. To the contrary, imposing higher penalties will only serve to destabilize the industry further. CMS is also looking for more consistent imposition of CMPs across the country. Increasing fines will not do that. CMS notes the increase of complaint surveys as another reason higher penalties are needed. It could be argued that the increase in complaint surveys is more due to the policies/procedures in place during the pandemic and the impact of staffing challenges which will not be alleviated by increased penalties. This is an extremely punitive proposed rule coming on the heels of the minimum staffing rule. Creating increased opportunities for penalties for facilities in the name of improving care will only serve to close many facilities faster. Skilled Nursing Facilities, serving the most vulnerable population, are on the precipice of financial insolvency due to the pandemic, staffing challenges and rules imposed by CMS that are not attainable nor sustainable.

Conclusion

THSC asks CMS to allow the not-for-profit nursing home providers to be a part of the solution to the problems that CMS has identified across the industry. We welcome further conversation and efforts that we can all agree will work towards the common good and sustainability of an industry on the brink.

Trinity Health Senior Communities appreciates the opportunity to submit our comments on the proposed Skilled Nursing Facility rule. If you have any questions, please feel free to contact Donna Wilhelm, Vice President of Advocacy for Trinity Health Continuing Care at donnaw@trinity-health.org.

Sincerely,

/s/

Jackie Harris, President/CEO
Trinity Health Senior Communities

2) CMS Quality Safety Oversite Letter dated October of 2019; QSO20-02-NHC Memo (cms.gov)