Trinity Health

September 12, 2024

Michael Chernew, Ph.D.
Chairman
Medicare Payment Advisory Commission
425 I Street, NW, Suite 701
Washington, D.C. 20001

Dear Dr. Chernew,

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.

As the commission continues to consider topics related to the 340B Drug Pricing Program, Medicare payment to hospitals, physicians, Skilled Nursing Facilities and Home Health, and telehealth in the new cycle, we urge MedPAC to:

- Appreciate legislative intent of 340B Drug Pricing Program when analyzing Medicare payments to 340B hospitals.
- Recommend adjustments for inpatient and outpatient hospital services that would provide a one-time retrospective adjustment to the market basket and allow for future retrospective adjustments.
- Recommend updates to physician reimbursement that more appropriately account for inflation.
- Consider how the SNF final staffing rule will significantly impact a SNFs ability to remain financially sustainable and continue to serve the most vulnerable patient populations without adequate Medicare reimbursement.
- Reconsider the proposed cuts to Home Health and how that would significantly impact an agency's ability to remain financially sustainable, address staffing shortages, and continue to serve the most vulnerable patient populations.
- Recommend removal of CMS' problematic high-and low-revenue thresholds for alternative payment models.
- Recommend permanent extension of telehealth flexibilities.

Our detailed comments on these issues are below.

340B DRUG PRICING PROGRAM

We have serious concerns about the direction that MedPAC has taken with regard to its analysis of the 340B program. Specifically, at its April 2024 meeting, MedPAC shared results of an analysis comparing Medicare fee-for-service payments for covered outpatient drugs purchased under the 340B program to 340B ceiling prices. While we appreciate that MedPAC did not offer any recommendations based on the analysis at this time, we think it is important to consider the facts we outline below should it continue this work in the 2024 – 2025 cycle.

For more than 30 years, the 340B Drug Pricing Program has provided financial help to hospitals (and other providers) serving highly marginalized communities to manage rising prescription drug costs. The program works by permitting certain hospitals to purchase covered outpatient drugs at a discounted price, generate savings, and use those savings to stretch limited federal resources to address the unique health care needs of their patients and communities. Trinity Health hospitals use 340B savings to support prescription access programs, infusion and oncology treatment options, and mobile outreach clinics, among other programs. These important patient benefits are put at risk when hospitals' 340B savings are cut.

The 340B program statute intentionally provides covered entities with additional funds by reducing the acquisition price on 340B drugs without changing hospitals' reimbursement under the Medicare program. It is precisely this delta between the hospital's acquisition price for the drug and the reimbursement received that allows 340B hospitals to meet the intent of the program and expand access to care for more patients. Therefore, MedPAC's finding that Medicare payments exceeded 340B ceiling prices is consistent with the purpose and design of the 340B program. If Medicare payments for 340B drugs were reduced, it would undermine the congressional intent of the program by reducing the 340B savings available for covered entities to maintain, improve and expand access to health care services for patients.

We also encourage MedPAC to analyze how 340B ceiling prices are set and the factors that influence those prices. 340B ceiling prices are based on two components: the average manufacturer price of the drug and a unit rebate amount. For brand-name drugs, which account for a majority of 340B volume, the unit rebate amount is statutorily set at 23.1%. However, the unit rebate amount is subject to an inflationary penalty where it can exceed 23.1% if a drug company decides to increase the price of the drug faster than the rate of general inflation. Drug companies routinely increase their prices faster and higher than the rate of inflation. A study by the Assistant Secretary for Planning and Evaluation found that from January 2022 through January 2023, approximately 2,000 drugs experienced price increases greater than inflation, with an average price increase of 15.2%. As a result, for many 340B drugs, the ceiling price is well below what is statutorily required, which leads to a greater difference between the ceiling price and the Medicare payment rate. Put another way, any gaps between ceiling prices and Medicare payment rates are a direct result of decisions by drug companies to increase drug prices — not hospitals. As such, already struggling 340B hospitals should not suffer rate cuts that mainly benefit drug companies. In fact, MedPAC itself has calculated that hospitals' Medicare margins are nearly negative 12%. Payment cuts for 340B drugs would make these margins worse, further jeopardizing hospitals' ability to furnish programs and services that are supported by 340B savings.

Given the important role that the 340B program plays in allowing hospitals to expand access to care for the patients and communities they serve, we urge MedPAC to carefully consider the negative consequences for patients and providers in any future efforts to cut Medicare payments to 340B hospitals.

INPATIENT AND OUTPATIENT HOSPITAL PAYMENTS

MedPAC has recommended CMS update Medicare payment rates for hospital inpatient and outpatient services by the current law amount plus 1.5%. We appreciate MedPAC acknowledging that the current market baskets are

below the cost of providing care to Medicare beneficiaries; however, this recommendation does not go far enough to ensure fair payment to providers.

Further, MedPAC has noted that in FY22, the hospital market basket forecast used to set payments was three percentage points lower than the cost increases hospitals actually experienced. This underpayment is one factor leading to significant financial challenges for Trinity Health and other health systems.

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.

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

To "true-up" and ensure payment reflects the cost of delivering care, we urge MedPAC to recommend that CMS:

- Use its special exceptions and adjustment authority to make a one-time retrospective adjustment 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.

PHYSICIAN FEE SCHEDULE UPDATES

We appreciate MedPAC's recognition that the current framework for physician payment is inadequate and that it is considering policy approaches to address these issues. The impacts of inflation and rising input costs continue to outpace the reimbursement for services covered by the physician fee schedule.

The annual cuts to the conversion factor are not sustainable for the mission of our health care system and each year, providers have been asked to do more with less. These continued cuts create long wait times for patients, lead to staff burnout and turnover, and increase the dissatisfaction of patients and providers. Further, the cuts do not occur in isolation and will exacerbate the financial pressures facing Trinity Health and similar providers. We continue to grapple with the extraordinary inflationary environment and continued labor and supply cost pressures. There is a widening gap between physician payment and increases in the Medicare Economic Index (MEI), and we have previously commented on the need to right size payment with inflation.

<u>Updating Physician Payment by MEI</u>

In its 2024 report to Congress, MedPAC recommended an update to the Medicare physician payment as outlined under current law plus a base conversion factor update of 50% of the Medicare Economic Index (MEI). While we directionally support updating physician payments by the MEI, the proposed approach is an insufficient update and would not cover the existing shortcomings in physician reimbursement. In addition, we agree with the concerns expressed by many commissioners that this approach could result in a negative compounding effect over time.

We understand the conversation factor cuts are a statutory requirement of the physician fee schedule as it was implemented, but the physician fee schedule is the only component of the CMS payment structure that doesn't have an appropriate inflationary factor built into base rates as they are created year after year. As a result of the

continued inflationary pressure and this approach to the Physician Fee Schedule, payments for professional services lag inflation by 29% dating back to 2001.

Trinity Health supports the Strengthening Medicare for Patients and Providers Act (H.R. 2474) that would update the conversion factor by an amount equal to the annual percentage increase in the MEI and we urge MedPAC to include this policy in its recommendation to Congress.

Further, it is critical that MedPAC educate Congress on the ramifications that the 2.5% conversion factor cut proposed in the CY25 physician fee schedule rule will have on the ability of healthcare providers to offer meaningful access to care for their Medicare beneficiaries and serve their communities. We encourage MedPAC to pursue annual updates to payment rates that are more in line with inflation and are made outside of budget neutrality.

Physician Payment and Site Neutrality

We are concerned that MedPAC frames many of their discussions and approaches on physician payment updates with a goal of reducing site-of-service payment differentials. Trinity Health strongly opposes site-neutral payments, which reduce access to critical health care services, especially in rural and other underserved areas. Site-neutral policies ignore fundamental differences between hospital outpatient departments (HOPDs) and other outpatient care settings.

Hospitals and health systems provide unique benefits to their community like providing 24/7 access to emergency care and special service capabilities such as burn, neonatal, psychiatric services, and more. In addition, HOPDs must maintain standby capacity for natural and man-made disasters, public health emergencies, other unexpected traumatic events. HOPDs also are required to comply with more regulatory and accreditation requirements, have more comprehensive licensing and safety codes and care for sicker, more complex patients than other care settings. Expanding site-neutral cuts would endanger the critical role hospitals and health systems play in their communities, including access to care for patients, especially the most medically complex.

CONTINUING CARE

Skilled Nursing Facility Payment Rate

MedPAC recommended that for fiscal year 2025, the Congress should reduce the 2024 Medicare base payment rates for skilled nursing facilities by 3%. In the June report, MedPAC reported, “In 2022, 88% of Medicare beneficiaries with Part A coverage lived in counties with three or more SNFs or swing bed facilities, and 5.8% of beneficiaries lived in counties with no or only one SNF or swing bed facility. These shares in 2022 are the same as in 2021. The presence of a facility alone does not ensure access because a facility may not have available capacity. For example, if a beneficiary lives in an area with very high occupancy, they may have a harder time accessing SNF care close to home. As of August 2023, about 6% of beneficiaries lived in a county where the average SNF occupancy rate was greater than 90%. About 45% lived in a county where the average SNF occupancy rate was between 80% and 90%, and about half lived in a county where the average SNF occupancy rate was lower than 80%. Even if a facility has an available bed, some beneficiaries may encounter access problems if they need specialized services or long-term care.”

These points all contribute to access concerns that will only be exacerbated by the final CMS Minimum Staffing Standard for Long-Term Care Facilities. An August 2024 report by the American Health Care Association (AHCA) revealed a worsening crisis around the ability of seniors and individuals with disabilities to access the long term and post-acute care they need. Some of the key points made in this report indicate the following:[1]

[1] AHCA ATC Report 2024 (8-13) V1 NK (ahcancal.org)

- Nursing homes would need to hire 102,000 additional nurses and nurse aides to meet the requirements, putting nearly one-quarter of nursing home residents (more than 290,000 individuals) at risk for displacement when facilities are inevitably forced to further reduce their census or close their doors altogether.
- Limiting Admissions: 46% of nursing homes are currently having to limit new admissions and 57% of nursing homes have a waiting list for new residents.
- Downsizing: Since 2020, there are 62,567 fewer nursing home beds and 20% of nursing homes have closed a unit, wing, or floor due to labor shortages.
- Closures: Since 2020, at least 774 nursing homes have closed, displacing 28,421 residents.

The report also shows there is no single factor that determines whether a nursing home can withstand economic pressures, limited government support, and growing workforce challenges. Since 2020, closures have happened at facilities with 4- and 5-Star Rankings, both at non-profits and proprietary centers, and across urban and rural communities. For rural communities in particular, the closure of a single facility could lead to devastating consequences for the community. The 2024 Access to Care report found that 40 additional counties in the United States became nursing home deserts since February 2020, with 85% of these nursing home deserts in rural communities.

CMS recently updated the SNF Medicare payment rate by 4.2%. And although we applaud the efforts of CMS to provide a rate increase that is more in line with current costs, it in no way addresses the magnitude of new costs related to the final staffing rule. By conservative estimates, Trinity Health Senior Communities (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 the initial estimate will be higher in two years.

Meeting the current and new challenges will require much more than a 4.2% Medicare increase. THSC fears that access will be heavily diminished once the final staffing rule is fully implemented. We ask that MedPAC consider the impact of this rule when making SNF payment recommendations, stop recommending cuts to SNF Medicare payment and recommend a 10% increase in rates to cover the final staffing rule.

<u>Home Health Payment Rates</u>
MedPAC recommends that, for calendar year 2025, the Congress reduce the 2024 base payment rate for home health agencies (HHAs) by 7%. The CMS proposed rate cut is an aggregate 1.7%. However, after modeling the numbers, accounting for the impact of multiple facets of this proposed rule including wage index changes, Trinity Health analysis confirms that we would suffer a reduction in our Medicare reimbursement of –2.42% or $4.9 million in CY25.

In addition to the proposed cuts, HHAs continue to struggle with recruitment and retention of qualified Home Health staff. Trinity Health at Home has budgeted a 3.8% wage increase for FY25 that translates to an annual cost of $6.1 million. This proposed cut would severely inhibit our ability to reward and retain staff. This creates a substantial barrier to access as workforce challenges continue to impact the industry. Trinity Health at Home tracks the number of referrals we are unable to take due to open positions. We compared the number of denials for the period of January-June of 2024 and January-June of 2019, pre-pandemic workforce, and the increase in referrals we cannot take due to staffing challenges has more than tripled. As recruitment and retention become more difficult this number will continue to grow.

Further rate cuts will inhibit our ability to sustain our Home Health ministry and reduce access to this preferred, lower cost care delivery. We recommend MedPAC consider the increased costs for staffing that Home Health is experiencing and recommend a 4% rate increase.

ADVANCED-ALTERNATIVE PAYMENT MODEL (A-APM) INCENTIVE PAYMENTS

Trinity Health supports MedPAC's approach to extend A-APM incentive payments. We, along with our partners, have urged Congress to do the same to facilitate the transition to value-based payment. Specifically, the Medicare Access and CHIP Reauthorization Act (MACRA) provided 5% incentive payments for clinicians participating in A-APMs to support non-fee-for-service programs like meal delivery programs, transportation services, digital tools and care coordinators which promote population health, among other services. These incentive payments have been critical to support organizations in transitioning to value-based care. However, MACRA only provided the A-APM bonuses through the CY 2024 payment period. The Consolidated Appropriations Act (CAA) of 2023 extended these bonus payments through 2025 (albeit at 3.5% vs. 5%), and the most recent CAA of 2024 included an extension through 2026 at 1.88%.

In addition, we encourage MedPAC to recommend removal of CMS' problematic high-and low-revenue thresholds for APMs as this distinction is arbitrary and creates real disincentives for ACOs that are looking to engage providers broadly, across the community and healthcare continuum, and include the highest-cost parts of the delivery system. If an ACO includes more providers across the continuum (mainly RHCs, FQHCs, CAHs and specialists), the ACO switches from low-revenue to high-revenue. This disincentive also makes it counterintuitive to CMS' desire to bring more providers into ACOs and coordinate care across the continuum.

The high-low revenue distinction is a flawed policy and CMS should not create policies that encourage one type of provider to participate in a voluntary program over another as this creates market distortions that may favor private entities and plans over local providers. It could also make health system ACOs question remaining in the program, because of the fear of additional policies that could greatly disadvantage them.

There are serious negative consequences for using this policy. For example, in the ACO Primary Care Flex Model, it blocks many of the providers that the program aims to serve. A high proportion of providers that the model targets are in high-revenue ACOs. Specifically:

- 67% of MD PCPs
- 68% of NPs
- 72% of Pas
- 87% RHCs
- 25% FQHCs
- 97% CAHs

Further, health system-led ACOs, such as Trinity Health, that have been strongly committed to alternative payment models and care coordination for our patients across the care continuum have been excluded from the model due to the arbitrary high-low revenue distinction. The model has created an unlevel playing field that impacts our ability to retain and attract providers to our ACO, as others are able to offer them prospective payments from the ACO Primary Care Flex Model.

TELEHEALTH

We appreciate MedPAC's continued discussion of telehealth utilization. Telehealth has always provided patients with increased access and convenience, but 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 can use telehealth services when needed, including the most disadvantaged.

Prior to the public health emergency (PHE), telehealth utilization was minimal due to limited fee-for-service coverage. Artificial barriers, such as requirements for patients to be located in specific settings (like clinics) or

geographies (limited to rural areas), meant that relatively few patients could benefit from telehealth services. Telehealth waivers implemented as a result of the PHE have contributed to improved access for millions of Americans, especially those with transportation or mobility limitations. Continuing these flexibilities is necessary to ensure patients' continued access to high-quality care. Yet, there is currently a patchwork of temporary waivers for telehealth services that, barring further action, will expire at the end of 2024. If this occurs, we risk a telehealth "cliff" that would negatively impact patient access in all communities.

Recognizing both the immediate and potential long-term benefits of telehealth, we recommend permanent extension of certain telehealth waivers, as we have communicated to Congress, including:

- Allowing all telehealth visits to be reimbursed when originated within the patient's home or location of their choosing.
- Allowing all Medicare patients access to telehealth, regardless of geographic location.
- Allowing clinicians to furnish and bill with parity of payment for in-office visits across all payers and settings.
- Ensuring audio-only remains a reimbursable option for physicians to care for patients who do not have audio and visual technology or capability.
- Allowing coverage of the facility component of telehealth offered in a provider-based clinic.
- Reimbursing providers for telehealth services in home health benefits.
- Including attribution to an ACO as evidence of an existing provider/patient relationship.
- Maintaining flexibility for remote-patient monitoring and reimburse for this service, including when provided through home health.
- Allowing clinicians to be reimbursed for telehealth when seeing new patients or a patient not previously seen at their practice.
- Removing limitations on frequency of services.
- Advancing policies that ensure access to affordable broadband, technology resources, and telehealth services for communities of color and other underserved populations.
- Allowing 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.

We encourage MedPAC to also recommend permanent extension of these provisions to support continued access for patients.

We thank you for consideration of these comments. Please contact jennifer.nading@trinity-health.org or 202-909-0390 if you or your team have questions or would like to discuss.

Sincerely,

Michael A. Slubowski

President & CEO
Trinity Health