Trinity Health
Senior Communities

June 9, 2024

Dr. Mehmet Oz, Administrator
Center for Medicare and Medicaid Services Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Subject: **(CMS-1827-P)** Medicare Program; Skilled Nursing Facility Prospective Payment System Fiscal Year 2026.

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

Dear Administrator Oz,

Trinity Health Senior Communities (THSC), a National Health Ministry of Trinity Health, is a faith-based organization that serves more than 700 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 Illinois, Iowa, Massachusetts, and Michigan to serve another 150 residents in need of skilled nursing services. We appreciate the opportunity to comment on (CMS-1827-P) Medicare Program; Skilled Nursing Facility Prospective Payment System (PPS) proposed update for Federal Fiscal Year 2026.Trinity Health is one of the largest not-for-profit, faith-based health care systems in the nation. It is a family of 127,000 colleagues and over 38,000 physicians and clinicians caring for diverse communities across twenty-six states. Nationally recognized for care and experience, the Trinity Health system includes 93 hospitals, 107 continuing care locations, the second largest PACE program in the country (a total cost of care program),142 urgent care locations and many other health and well-being services. In fiscal year 2024, the Livonia, Michigan-based health system invested $1.3 billion in its communities in the form of charity care and other community benefit programs. 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. In addition, the comments below are recommendations on modifications to the Medicare fee-for-service payment system. Many of these issues would be lessened, or in some cases eliminated, if CMS gave non-profit health systems, such as Trinity Health, more accountability in total cost of care payment and delivery arrangements.

Our comments on the proposed rules for Skilled Nursing Facilities (SNFs) are provided with a sense of impending crisis as we face increase regulatory requirements, workforce challenges and proposed threats to Medicaid that 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 current workforce and market trends as well as any threats that will ultimately have negative impacts on the industry.

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:

2026 Proposed Payment Updates: For FY 2026, CMS proposes updating SNF PPS rates by 2.8% based on the proposed SNF market basket of 3.0%, plus a 0.6% market basket forecast error adjustment, and a negative 0.8% productivity adjustment. THSC remains concerned about lagging market basket updates in the face of increasing financial pressures' and believes this percent rate increase fails to recognize the challenges that are plaguing the long-term care industry since the pandemic. The current health care environment presents challenges that are due to staffing shortages, inflation and increased cost of supplies, and regulatory mandates that continue to drive costs up with negligible impact on outcomes, such as:

- The requirement for Enhanced Barrier Precautions which require glove and gown use during high contact resident care activities for residents that are known to have history of multi-drug-resistant organisms has driven up supply costs. On April 1, 2024, CMS updated the following survey critical element pathways (CEPs) due to the enforcement of enhanced barrier precautions (EBP) outlined in QSO-24-08-NH.)
- The reporting of infections to the national health and safety network is driving up administrative costs. F880- QSO-25-11-NH
- The focus on mental health needs and antipsychotic reduction in long term care and associated change to surveyor guidance requires more hours of documentation and training of clinical staff, social services, and administrators. QSO 25-07-NH revised-long-term-care-ltc-surveyor-guidance-significant-revisions-enhance-quality-and-oversight-ltc.pdf

The health care workforce challenges remain in senior living with an incredibly competitive market for licensed nurses, certified nursing assistants, dining staff, among others. 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 is 3.8% while inflation on supplies is hovering around 3%. Additionally, we project the economic impact from new tariffs to increase our supply costs by 3%.

THSC asks CMS to increase the SNF payment rate to be reflective of the current regulatory, workforce, and inflationary environment.

Patient-Driven Payment Model (PDPM), ICD-10 Mappings: CMS is proposing several changes to the PDPM ICD-10 code mappings to allow providers to provide more accurate, consistent, and appropriate primary diagnoses that meet the criteria for skilled intervention during a Part A SNF stay. Aligning PDPM ICD-10 codes with the latest ICD-10 coding guidance is a positive step in providing clarity, more accurate, consistent, and appropriate primary diagnosis that meet criteria for skilled intervention under a Part A SNF stay. **THSC supports this proposed change.**

SNF Value-Based Purchasing (VBP) Program: CMS is proposing a few adjustments to the SNF VBP program. THSC is pleased that CMS is proposing to adopt a reconsideration process that will allow SNF's to appeal CMS' initial decisions for Review and Correction requests prior to any data being publicly available. In addition, CMS proposed to remove the health equity adjustment. The goal of the adjustment was to improve access to care and address health care disparities. This can be better achieved by financial support for the Medicaid system which is a safety net for vulnerable seniors and through increasing Medicaid payments to nursing homes. A Health Services Research study (2018) reported that Medicaid dependent nursing homes have a 3.5 percentage point lower operating ratio and a 1.20 lower quality rating leading to higher financial stress and lower quality of care.[1]

SNF Quality Reporting (QRP): For the SNF QRP, CMS is proposing to remove four standardized patient assessment data elements beginning October 1, 2025, including one item for "living

1) Geographic Disparities in Access to Nursing Home Services: Assessing Fiscal Stress and Quality of Care - PubMed

situation," two items for "food," and one item for "utilities;" amend the reconsideration request policy and process. THSC feels that the removal of four data elements under the Social Determinants of Health category lessens the administrative burden upon staff at our nursing homes. Collection of this data is burdensome and capturing the data accurately is difficult. THSC also feels that the proposal to amend the reconsideration policy and process is a positive step. THSC agrees with the benefits of more timely quality data and the use of Fast Healthcare Interoperability Resources in the SNF QRP.

Timely and seamless data sharing for improvement in quality has been lacking in skilled nursing. Reduction of the SNF QRP data submission deadline from 4.5 months to 45 days is a positive step to improve the timeliness and actionability of SNF QRP quality measures. This would allow for the public to view data that reflects a more accurate picture of the current quality of a facility and allow the facility to use data for quality improvement in more real time. We believe there would be limited impact to workflow based upon the proposed change.

THSC would like to see the elimination of the Covid and Influenza Vaccine measure. We believe there is excess reporting of this measure. Facilities capture this data in each resident's medical record, track vaccine data through their infection control program, code vaccine data on the MDS and report this data to NHSN. During the annual health inspection there is a comprehensive review of the facility infection control program which includes a review of vaccination protocols with citations assigned for noncompliance. Allowing validation through the survey process and removing the measure from the QRP would eliminate another administrative burden and reduce costs with no impact to resident care.

Request for Information on Streamlining Regulations and Reducing Administrative Burdens in Medicare: THSC requests the following regulations be amended or eliminated:

Regulation: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting

Trinity Health Senior Communities requests that this rule be eliminated in its entirety.

Code: 42 CFR 483.35(b) and (c)

The Minimum Staffing Standards for Long-Term Care Facilities final rule was published in the Federal Register on May 10, 2024. This rule requires nursing homes to have a registered nurse on-site twenty-four hours per day, seven days per week in every nursing home, regardless of the assessed needs of the unique resident population or the skills and competencies of the existing staff. The rule further requires all nursing homes to provide 3.48 hours per resident, per day or total nurse staffing, including 0.55 hours per resident, per day of registered nurse services and 2.45 hours per resident, per day of nurse aide services. This requirement exceeds the statutory requirement to provide 24-hour licensed nurse services sufficient to meet the needs of residents and to use the services of a registered nurse at least eight consecutive hours per day, seven days per week. Inability to meet staffing standards may cause nursing homes to limit admissions, take beds offline, or close entirely, resulting in barriers to access for older adults seeking skilled nursing or long-term care.

In May 2024, the American Health Care Association filed a lawsuit claiming, among other complaints, that the Centers for Medicare & Medicaid Services (CMS) exceeded statutory authority in issuing these requirements. LeadingAge joined the lawsuit in June 2024 as co-plaintiff. On April 7, Judge Matthew Kacsmaryk of the United States District Court for the Northern District of Texas, Amarillo Division, issued his decision finding that CMS indeed had exceeded statutory authority and vacating the requirements.

The rule would also require Medicaid state agencies to report annually to CMS the amount of nursing home Medicaid payments spent on compensation of the direct care workforce. This

reporting by state agencies would require reporting from individual nursing home providers to the state agency in order for the state agency to report the information to CMS. Reporting the amount of Medicaid payments spent on direct staff compensation is an administrative burden that does not meet the intent of the requirement and creates opportunity for inaccurate conclusions to be drawn about Medicaid spending that could negatively and erroneously influence future policies. Requiring reporting on the percentage of Medicaid payments spent on compensation implies that compensation of direct care and support staff are the only valid uses of Medicaid dollars. In fact, there are many valid expenses outside of direct care staff compensation on which Medicaid payments are spent. Evaluating, testing, and revising emergency plans and updating resident rooms from multiple occupancy to private rooms with improved ventilation are examples of important uses of nursing home funds that would be overlooked with this type of reporting requirement.

Regulation: Respiratory Illness Reporting

Trinity Health Senior Communities requests that this requirement be rescinded as it is unnecessary and duplicative of other federal requirements.

Code: 42 CFR 483.80(g) Infection Control, Respiratory illness reporting.

Under infection control requirements, nursing homes must report information on acute respiratory illnesses, including influenza, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), and respiratory syncytial virus (RSV) through a standardized format and frequency specified by the Secretary.

At present, this format and frequency is weekly reporting through the National Healthcare Safety Network (NHSN) system, an online reporting platform that is developed, maintained, and utilized by the Centers for Disease Control & Prevention (CDC). The data currently reported includes facility census, resident vaccination status for the three identified respiratory illnesses, confirmed cases among nursing home residents for each illness, and hospitalizations of nursing home residents for each illness.

Weekly reporting of respiratory illness data was initiated during the COVID-19 public health emergency. At that time, a strong federal response was needed to monitor this catastrophic new virus and coordinate state and federal strategies for preventing and responding to outbreaks. The data was used to learn about this novel virus as well as inform the distribution of supplies and support from the federal government to state and local governments and entities. However, we have learned much in the five years since this virus emerged and the impact of the virus has significantly changed.

We are no longer in a national public health emergency and the federal government is no longer involved in large-scale efforts to provide resources and support coordinated response to long-term care. Allocations of PPE from HHS ended mid-way through the PHE, and strike teams are also a relic of the early days. Similarly, while nursing homes continue to receive support from public health, these responses are local activities, not federal response efforts, and are driven by local conditions within the state or region rather than conditions across the country.

We note that public health entities would continue to have access to data on respiratory illness outbreaks, even without NHSN data, due to separate existing requirements to report outbreaks to public health authorities. Per these requirements, nursing homes would continue to report clusters of respiratory virus symptoms and confirmed cases to public health, allowing for continued situational awareness, support, and outreach.

Regulation: Civil Money Penalties: Basis for Imposing Penalty

Trinity Health Senior Communities requests that this requirement be eliminated, as it imposes undue financial burden on nursing homes.

Code: 42 CFR 488.430 Civil Money Penalties: Basis for Imposing Penalty

Nursing homes are cited for noncompliance with Requirements of Participation through the survey and certification process. As a result of findings of noncompliance, CMS or the state may impose financial penalties on the nursing home in an effort to ensure a return to and maintenance of compliance. Requirements at 42 CFR 488.430 give CMS or the state survey agency the authority to enforce multiple financial penalties for a single type of noncompliance, such as per day and per instance civil money penalties, regardless of whether or not the deficient practice constituted immediate jeopardy.

Allowing CMS or the state to impose multiple penalties on the nursing home for noncompliance creates barriers to quality improvement. When nursing homes are assessed large fines for noncompliance that was promptly corrected, they have less money available for the care and services residents depend on. This means less money is available to recruit and retain staff, implement quality improvement initiatives, or make improvements to the physical environment such as renovating outdated physical structures to improve indoor air quality and accommodate private rooms.

Nursing homes facing extreme financial hardship may even be forced to amend operations including the need to reduce resident programs, reduce staff, reduce admissions, or close entirely, creating access issues for older adults seeking nursing home care.

Eliminating this requirement will lessen the punitive overreach of CMS and state agencies and allow providers more financial flexibility to address areas of noncompliance and needed quality improvement.

Regulation: Resident assessment, Preadmission screening for individuals with a mental disorder and individuals with intellectual disability

Trinity Health Senior Communities requests that this requirement be rescinded as it represents outdated and unnecessary requirements that are unduly burdensome.

Code: 42 CFR 483.20(k) Resident assessment, Preadmission screening for individuals with a mental disorder and individuals with intellectual disability

This requirement was implemented as a result of the 1987 Omnibus Budget Reconciliation Act (OBRA ’87) to prevent unnecessary placement of individuals with mental illness or intellectual disabilities in nursing homes. Under these requirements, nursing homes must complete preadmission screening to determine that individuals with mental illness or intellectual disabilities require the level of services provided by the nursing home. These preadmission screenings require the state mental health or intellectual disabilities authority to decide based on an independent physical and mental evaluation performed prior to admission by a person or entity other than the state authority or nursing home. Both the evaluation and the determination by the state authority often require agency coordination that causes unnecessary delays in admission to the nursing home.

While inappropriate placement of individuals with mental illness or intellectual disabilities in nursing homes must still be prevented, requirements for pre-admission screening and referral as operationalized through 42 CFR 483.20(k) are unnecessary due to subsequent requirements implemented through the 2016 Mega Rule, “Requirements for Participation in Medicare and

Medicaid Programs" that require resident assessment and care planning for all residents ensure that the needs of residents are identified and addressed, and that nursing homes do not admit residents whose needs they are unable to meet. Requirements at 42 CFR 483.30 require that physicians personally approve, in writing, recommendations for individuals to be admitted to the nursing home. According to requirements at 42 CFR 483.21(a)(1), nursing homes must assess a resident's needs and develop a baseline care plan within 48 hours of admission. Per requirements at 42 CFR 483.20(b) and 483.21(b), a comprehensive assessment must be completed within 14 days of admission and a comprehensive care plan developed within 7 days of the assessment, and both the assessment and care plan must be reevaluated upon a significant change in functioning or at least quarterly thereafter.

These requirements for assessment and care planning ensure that individuals with mental illness or intellectual disabilities are appropriately placed and that their needs are promptly identified and addressed. Eliminating PASARR requirements at 42 CFR 483.20(k) will lessen administrative burden on both nursing home providers and state agencies while also preventing unnecessary delays in admission for individuals in need of nursing home care.

As CMS reviews regulatory burdens on providers, it would be prudent for the Agency to consider the impact of some regulations on the patient and family. Today's network of post-acute care is difficult to navigate. Seniors who are transitioning between levels of care oftentimes do not clearly understand the maze of care levels including why they are transitioning, what the requirements are, and what Medicare and/or Medicaid will pay for, if anything. It is a regulatory maze of rules and guidelines that often differ by state and provide little to no guidance for families dealing with the needs of a loved one. Trinity Health encourages CMS to establish a work group of post-acute providers to define and ultimately produce guidance for people, both patient and families, who are navigating the post-acute care continuum. Trinity Health Continuing Care would be honored to assist CMS in this task.

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/

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Chief Operating Officer
Trinity Health Senior Communities