Trinity Health
Senior Communities

May 28, 2026

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-1843-P)** Medicare Program; Skilled Nursing Facility Prospective Payment System Fiscal Year 2027.

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 three additional skilled nursing communities in Illinois, Iowa, and Massachusetts to serve another 66 residents.

We appreciate the opportunity to comment on (CMS-1843-P) Medicare Program; Skilled Nursing Facility Prospective Payment System (PPS) proposed update for Federal Fiscal Year 2027.

- **Any payment update should be reflective of current workforce and market trends, the proposed 2.4% does not do that.**
- **CMS should engage providers with transparent data review and conduct pilot testing before implementing any PDPM recalibration.**
- **CMS should establish a process that provides SNFs with a grace period to meet submission requirements.**
- **CMS should provide adequate funding to support the additional MDS requirement if it is finalized.**
- **CMS should implement a Value-Based Purchasing program methodology that will result in a 70 percent payback percentage each year, the maximum currently authorized by statute.**

Trinity Health is one of the largest not-for-profit, Catholic health care systems in the nation. It is a family of 133,000 colleagues and 30,000 physicians and clinicians caring for diverse communities across 23 states. Nationally recognized for care excellence and patient experience, the Trinity Health system includes 91 hospitals, 101 continuing care locations, and the second largest PACE program in the country (a total cost of care program). Trinity Health has 15 medical groups with 8,900 medical group physicians and providers. With headquarters based in Livonia, Michigan, its annual operating revenue is $25.4 billion with $2.9 billion returned to its communities annually in the form of charity care and other community benefit and community impact programs.

Trinity Health has 12 Clinically Integrated Networks (CINs) that are accountable for 2 million lives across the country through alternative payment models. Our health care system participates in 12 markets with Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs), which includes 10 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 12 markets also participate in the Comprehensive Primary Care Plus Model. 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.

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 sincere concerns. Our organization exists to serve older adults and individuals with complex medical needs as an extension of our mission-driven commitment to dignity, compassion, and stewardship. As a nonprofit provider, we reinvest all available resources back into resident care, workforce support, and facility sustainability rather than shareholder return. Many of the residents we serve rely on Medicare and Medicaid as their primary source of coverage, and we frequently care for individuals with high medical, functional, and psychosocial acuity who might otherwise struggle to access post-acute or long-term care services. 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:

2027 Proposed Payment Updates: For FY 2027, CMS proposes updating SNF PPS rates by 2.4% based on the proposed SNF market basket of 3.2%, and a negative 0.8% productivity adjustment. However, as CMS notes, this estimate does not incorporate the SNF Value-Based Purchasing (VBP) reductions that are estimated to reduce aggregate payments by $203 million. Taken together, the combined impact of the proposed rule is a modest increase of $685 million (+1.85 percent).

We strongly support CMS's goals of advancing quality, transparency, and accountability in the nursing home sector. However, nonprofit, faith-based providers operate with uniquely thin operating margins, limited access to capital, and heightened obligations to sustain services regardless of market conditions. As such, payment adequacy is not an abstract policy issue—it is foundational to our ability to uphold our mission, maintain a stable and well-trained workforce, and ensure continued access to skilled nursing care in the communities we serve.

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. The current health care environment presents challenges due to staffing shortages, inflation, and increased cost of supplies.

The proposed payment update for FY 2027 falls significantly short of meeting the financial realities faced by SNFs today. This modest update does not adequately account for ongoing inflation, rising operational costs or the persistent workforce shortages that continue to strain post-acute care providers. THSC expects inflationary increases to be at minimum 4%-5%. For nonprofit and faith-based SNFs operating on thin margins, ongoing underfunding directly threatens mission fulfillment and resident access.

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% and benefits are 10% while inflation on supplies is hovering around 4.5%.

THSC asks CMS to reassess the market basket and productivity adjustment and increase the SNF payment rate to be reflective of the current workforce and inflationary environment.

Patient-Driven Payment Model (PDPM) Case-Mix RFI: THSC cautions CMS against assumptions that observed increases in PDPM case-mix reflect inappropriate coding rather than true resident acuity growth. Hospitals are discharging patients sooner and sicker, and SNFs are appropriately documenting increased clinical complexity. Evidence indicates that SNFs are serving more medically complex patients post-PDPM, including individuals

requiring advanced nursing care.[1] Across-the-board case-mix reductions would disproportionately impact high-acuity and mission-driven providers. **THSC recommends that CMS should engage providers with transparent data review and conduct pilot testing before implementing any PDPM recalibration.**

Expansion of Quality Reporting and Data Collection Period: THSC supports CMS efforts to enhance data transparency and quality. Should CMS finalize the policy requiring data submission on the 15th day of the second month after the end of the calendar quarter beginning with FY 2029, **THSC urges CMS to establish a process that provides SNFs with a grace period to meet submission requirements.** This may require a transitional period beginning with the first several data submission cycles in FY 2029 where SNFs are afforded additional time beyond the 15th day of the second month to submit data without incurring a 2.0 percentage point reduction in the SNF PPS annual update factor.

MDS Data Submission: CMS proposes, beginning with the FY 2031 SNF QRP, to require submission of Minimum Data Set (MDS) data on each resident receiving covered skilled care in a SNF, regardless of payer. Currently, MDS data is submitted for only Medicare fee-for-service (FFS) residents. Given the overall decrease in Medicare FFS residents and the growth of Medicare Advantage enrollees, CMS believes the proposal will greatly improve the SNF QRP. Importantly, CMS affirms the proposal would ensure MDS data from non-Medicare FFS residents is *not* used to update the payment rates used under the SNF PPS. This action would significantly increase administrative burden without associated reimbursement support. For nonprofit providers serving large Medicaid populations, this requirement diverts limited resources away from direct resident care. **THSC recommends that should this rule be finalized, adequate funding to support the additional requirement be made. In addition, if finalized, this rule should be phased-in to mitigate unintended consequences to access to care.**

Removal of Covid-19 Measures: THSC strongly supports CMS's proposal to remove COVID-19 vaccination measures from the SNF Quality Reporting Program. These measures no longer reflect emergency conditions and do not meaningfully measure current quality performance.

SNF Value-Based Purchasing: The continued 2% Part A withhold under the SNF Value-Based Purchasing Program functions as a permanent payment reduction, particularly affecting safety-net, nonprofit providers. For FY2027 CMS is proposing to continue the payout at 60%. Based on the FY26 VBP incentive factors our Medicare revenue is expected to be decreased by $440,000 annually due to the VBP program. This reduces the proposed PPS increase of 2.4% to a meager .7% increase. However, for FY27 there will be 4 additional Program Measures included in the VBP calculation which will impact the Incentive Factor calculation, so this estimate could potentially be overly optimistic, and the losses could be much higher than expected. Our ministry cannot remain sustainable with these potential and realized losses. THSC recommends that CMS reevaluate the size and redistribution methodology of the withhold to ensure fairness and sustainability. **CMS should implement a Value-Based Purchasing program methodology that will result in a 70 percent payback percentage each year, the maximum currently authorized by statute.**

RFI: Advanced Care Planning (ACP): ACP is a continuous process of conversation and documentation to align a patient's care and interventions with their beliefs, values, and preferences, in the event they become unable to make those decisions.

There are many barriers to Advanced Care Planning in the Long-Term Care (LTC) setting.

1. Cognitive impairment: It is estimated that nearly 60% of LTC residents have a diagnosis of dementia. Progressive illnesses like dementia hinder the ability to engage in planning, while family members acting as proxies often face high levels of stress and uncertainty. They often avoid discussing end of life topics as they are in denial of their loved one's prognosis and rely on their own experiences, cultural and religious beliefs more than objective data/sources in making care decisions.

2. Mistrust of the healthcare system: Studies show that people are more likely to discuss advanced care planning with someone with whom they have a trusted relationship. Residents in a SNF setting most often have a short term stay with a Provider they are unfamiliar with in charge of their care. It's much less emotionally fraught and

[1] Prusynski, R. A., Humbert, A., Amaravadi, H., Middleton, A., Leland, N. E., Saliba, D., Brown, C., Freburger, J., & Mroz, T. M. (2026). Patient Functional Outcomes in Skilled Nursing Facilities: The Mediating Role of Declining Therapy. *Archives of physical medicine and rehabilitation*, *107*(4), 640–647. https://doi.org/10.1016/j.apmr.2025.09.018

effective to have these discussions in the outpatient setting, with providers that the patient/family already has a long-standing relationship with.

3. Lack of preparedness: LTC residents and Power of Attorneys (POAs) are not prepared to have end-of-life discussions. Specifically, the POA's struggle or are in denial of accepting the LTC resident's poor prognosis, and their difficulty understanding the limitations and complications of life sustaining therapies.

4. Concern lies in exactly what would be measured in this area. Advanced Care Planning is a very personal decision. Many residents cannot or will not discuss end of life issues due to their personal beliefs. Residents that are being admitted to the SNF are increasingly sicker, suffering from higher acuity levels, multiple comorbidities, and complex needs.

THSC recommends Advanced Care Planning begin much earlier than when a person reaches end of life. Using ACP as a Quality measure for nursing homes does not reflect the quality of care being delivered and should not be added as a quality metric for nursing home providers.

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. As a nonprofit and faith-based nursing home provider, THSC is deeply committed to caring for medically complex, vulnerable older adults. Payment adequacy is essential to preserving access, quality, and workforce stability. We respectfully urge CMS to consider these comments as it finalizes the FY 2027 SNF PPS rule.

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/

Stacey Johnson DNP, RN, HFA, NEA-BC
Chief Operating Officer
Trinity Health Senior Communities