



September 10, 2026

Dr. Mehmet Oz, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1848-P; Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

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

Dear Administrator Oz,

Trinity Health appreciates the opportunity to comment on policies set forth in CMS-1848-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 133,000 colleagues and nearly 40,000 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 Program of All-Inclusive Care for the Elderly (PACE) in the country. 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 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 1.8 million lives across the country through alternative payment models. Our health care system participates in 10 markets with Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs), which includes 8 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). 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 addition, Trinity Health owns a non-profit, mission-focused Medicare Advantage plan—MediGold—that plays a vital role in our integrated delivery network and provides care coordination for patients while using fair practices.

In addition, Trinity Health owns a non-profit, mission-focused Medicare Advantage plan—MediGold—that plays a vital role in our integrated delivery network and provides care coordination for patients while using fair practices. Serving 56,000 beneficiaries across 6 states, MediGold is a highly-effective best practice plan model. In order to place a better emphasis on care and outcomes rather than profit, MediGold has a lower profit margin and lower administrative costs compared to commercial for-profit plans because they say “yes” more to providers and

beneficiaries. In addition, MediGold utilizes standard and transparent guidelines for decisions on precertification and other authorization approval processes, removing ambiguity of guidelines for providers.

We are eager to work with Congress and the Department of Health and Human Services (HHS) on alternative payment models that enable providers to move away from fee-for-service and assume responsibility for total cost of care and outcomes for populations served by public programs. Our participation in Medicare demonstration projects, our MediGold MA plans and our PACE programs demonstrate our ability to effectively manage cost and outcomes.

In our detailed comments below, we recommend that CMS:

- Work with Congress to find a permanent solution that would update the conversion factor annually by an amount equal to the annual percentage increase in the Medicare Economic Index.
- Not replace the PE methodology with untested changes given the potential to significantly redistribute payment across specialties and sites of service
- Focus on supporting true longitudinal care management when considering the E/M complexity codes.
- Not finalize the proposal that would reduce payment when a separately identifiable O/O E/M visit is furnished by a physician as there are already policies to account for this and CMS does not have data to justify this policy.
- Finalize the advanced care planning proposal, as these codes have been underutilized.
- Finalize the shared medical appointment policy, while clarifying that medical nutrition therapy (MNT) services may be billed separately.
- Ensure that access is preserved to MNT furnished by registered dietician nutritionist when finalizing the health coaching policy.
- Strengthen the diabetes self-management training (DSMT) benefit by removing the current one-year expiration on the initial 10 hours of DSMT, allow DSMT and MNT be furnished and billed the same day, and make telehealth reimbursement for these services permanent.
- Expand coverage of MNT by allowing MNT CPT codes 97802, 97803, and 97804 to be used for a broader range of nutrition-related chronic conditions beyond the currently covered indications.
- Leverage data submitted through either the rebate model OR the 340B data repository—not both—do reduce administrative burden on covered entities.
- In lieu of the proposed policies for remote patient monitoring (RPM) and remote therapeutic monitoring (RTM), we urge CMS to reinforce the role of the primary care physician or treating practitioner in authorizing and overseeing these services to ensure appropriate utilization while preserving provider flexibility and patient access.
- Make modifications to the Medicare Shared Savings Program, including:
 - Consider additional modifications to mitigate the ratchet effect that occurs when ACOs successfully lower expenditures during an agreement period.
 - Increase the cap on upward adjustments to the historical benchmark.
 - Retain the maximum weight of the positive regional adjustment at 50% for ENHANCED Track ACOs.
- Make modifications to the Quality Payment Program including:
 - Retain the lower thresholds and permanently extend the Advanced APM bonus.
 - Do not make QP and Partial QP determinations at the TIN/NPI level.
 - Exempt ACO-participating providers from mandatory MVP reporting requirements.

- Stagger the transition to digital quality measures (dQMs) and the transition from MIPS to required MVPs, so that we can focus first on a successful transition to dQMs.
- Ensure that sufficient dQMs are available for all specialties that will be required to report through the Ambulatory Specialty Model (ASM) or a MIPS Value Pathway (MVP).
- Through comments on the APM, primary care, and palliative care RFIs, Trinity Health includes recommendations on future policies.

PHYSICIAN PAYMENT

The proposed conversion factor for 2027 is \$33.1696 for qualifying participants (QP) and \$32.84090 for non-QP. Overall, the rule would decrease payments to physicians by reducing the QP conversion factor by a net 1.19% and the non-QP conversion factor by a net 1.68% in CY 2027. **Trinity Health is deeply concerned with how these cuts will impact access and patient care, especially as we face critical workforce shortages and inflationary increases in wages, pharmaceuticals and medical supplies.**

These annual cuts are not sustainable for the mission of our healthcare system and each year, we 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.

The proposed payment is a critical reminder that patients and physicians desperately need Congress to develop a *permanent* solution that addresses the financial instability and threatens access to care. Physician payment must increase via an inflation-based payment update based on the full Medicare Economic Index.

We urge CMS to use any and all available authorities to eliminate payment cuts and work with Congress to find a permanent solution for these cuts. 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 Medicare Economic Index. 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. However, it is important that CMS explain to Congress the ramifications that the cut will have on the ability of healthcare providers to offer meaningful access to care for their Medicare beneficiaries and serve their communities.

PRACTICE EXPENSE (PE) METHODOLOGY

CMS proposes several changes to its indirect PE allocation methodology:

- allocate indirect PE using both the work RVU and the clinical labor portion of the direct PE RVU for all services, except for codes with 010- and 090-day global periods
- phase out the part of its methodology that ensures the overall number of PE RVUs by specialty are consistent with survey data from 2007 or earlier in an effort to reduce reliance on specialty-specific PE/HR survey data
- further refine its indirect PE allocation methodology for services furnished in facility and non-facility (office-based) settings

CMS should not replace the PE methodology with untested changes given the potential to significantly redistribute payment across specialties and sites of service. We urge CMS to thoroughly evaluate proposed changes prior to finalization into the methodology. Implementing multiple revisions to the 18-step PE calculation simultaneously creates substantial risk of unpredictable and potentially significant payment shifts across specialties and services. In addition, CMS should provide a transparent code and specialty-level impact analyses before finalizing the proposed changes.

CMS should also adopt a more measured implementation approach when incorporating changes into the PE calculation methodology. At a minimum, CMS should extend the phase-in period where projected PE RVU changes exceed the cap over multiple consecutive years and establish a process to monitor claims experience, assess unintended consequences, and revise the methodology as necessary.

E/M VISIT COMPLEXITY ADD-ON

The rule would replace HCPCS code G2211 with a modifier, maintaining an equal percentage increase across all levels of E/M codes.

We strongly support policies that increase reimbursement for primary care and better account for the ongoing work involved in managing complex patients over time. **G2211 has expanded beyond primary care and while there may be justification for extending complexity add-on codes to a limited number of specialties with ongoing relationships and significant care coordination responsibilities, such as oncology and cardiology, CMS should remain focused on supporting true longitudinal care management.**

E/M RESOURCE OVERLAP BETWEEN STANDALONE VISITS AND GLOBAL PERIODS

The rule would reduce payment when a separately identifiable O/O E/M visit is furnished by the same physician (or a physician in the same group practice) on the same day as a 0-, 10- or 90-day global procedure. The highest paid service (either surgical or E/M visit) would be paid at 100% and all other services furnished on the same day would be paid at 50%.

CMS should not finalize this proposal as it would be detrimental to patient-focused care. While CMS assumes there is "likely overlap and duplication" between these services, the agency has not presented evidence demonstrating that the work associated with a separately identifiable E/M visit overlaps with the procedure to the extent that a 50% payment reduction is warranted.

Moreover, Medicare's existing valuation methodology already accounts for efficiencies and overlapping resources when services are commonly furnished together. **Trinity Health supports maintaining the current policy permitting use of modifier-25 to indicate that an E/M visit is significant, separately identifiable, and complementary to—rather than duplicative of—the pre- and post-operative care associated with a procedure furnished on the same day.**

We are also concerned that CMS considered and ultimately declined to finalize a similar policy in the CY 2019 Medicare Physician Fee Schedule due to concerns regarding beneficiary access. CMS has not presented compelling new evidence to address those concerns or justify revisiting this policy. To avoid payment reductions, providers may be forced to separate E/M visits and procedures into multiple appointments, requiring patients to return on another day. This would increase beneficiary burden, delay care, and scheduling challenges, and potentially increase overall healthcare costs.

Finally, CMS acknowledges that the resulting budget neutrality impact would be minimal, meaning the broader Medicare program derives little benefit while affected providers could experience significant payment reductions. More importantly, this policy could negatively impact patients, particularly those with multiple chronic conditions and complex care needs.

ADVANCED CARE PLANNING

CMS proposes to establish two new HCPCS codes to describe advance care planning (ACP) services furnished by clinical staff under the direct supervision of the billing practitioner. The agency further proposes that the existing ACP CPT codes 99497 and 99498 would be used only for time personally spent by the billing practitioner. CMS states these proposals would more accurately distinguish and value the work performed by billing practitioners from that of their clinical staff.

Trinity Health supports this policy. There is a lot of work being done by clinicians doing care management planning and existing codes have been underutilized and underbilled.

Advance care planning is often delivered through a team-based approach, and a significant portion of the work associated with patient outreach, education, care planning, documentation, and follow-up is performed by nurses, social workers, and other clinical staff. As CMS finalizes this policy, we encourage the agency to ensure that the new coding framework does not inadvertently undermine or devalue the important contributions of non-providers.

SHARED MEDICAL APPOINTMENTS

Shared medical appointments (SMAs) are an approach to offer a group-based environment in which beneficiaries can receive clinical guidance while also engaging with peers facing similar health challenges. Currently there is no CPT or HCPCS code specifically designated for SMAs. Therefore, CMS proposes to create coding and valuation specifically for SMAs.

We appreciate CMS's proposal to recognize and support SMAs as an innovative care delivery model that can improve patient engagement, increase access to care, reinforce self-management, and promote efficient use of clinical resources for beneficiaries with chronic conditions. CMS's acknowledgment of SMAs reflects the growing body of evidence demonstrating their value in advancing coordinated, team-based care and improving health outcomes. **We encourage CMS to clarify that Medical Nutrition Therapy (MNT) services may be billed separately when furnished and documented in accordance with existing Medicare requirements during an SMA.** Registered Dietitian Nutritionists provide distinct, evidence-based services that complement the broader goals of SMAs and are critical to the management of conditions such as diabetes, cardiovascular disease, and chronic kidney disease.

Allowing separate billing for MNT codes within SMAs would support interdisciplinary care, expand beneficiary access to nutrition services, and ensure appropriate reimbursement for separately identifiable professional services. We urge CMS to explicitly permit separate billing of applicable MNT codes when all Medicare coverage and documentation requirements are met.

HEALTH COACHING

The rule would establish a national Medicare Part B payment pathway for health and well-being coaching services, utilizing CPT Category III codes 0591T, 0592T, and 0593T to cover initial assessments, individual follow-up sessions, and group coaching.

CMS's proposal to establish reimbursement for health coaching services is an important step toward expanding access to preventive, patient-centered care and supporting beneficiaries in achieving sustainable behavior change. **As CMS finalizes this policy, we encourage the agency to recognize that Registered Dietitian Nutritionists (RDNs) possess extensive education and training in motivational interviewing, behavior change theory, health education, effective communication, nutrition assessment and intervention, outcomes monitoring, and clinical decision-making that encompass and extend beyond health coaching competencies.**

CMS should clearly state that health coaching is not intended to replace, duplicate, or limit access to MNT when a nutrition-related condition is present and MNT is clinically indicated. To preserve beneficiary access to appropriate care, CMS should maintain separate reimbursement structures for MNT and health coaching that reflect the distinct clinical complexity, professional training, and scope of services associated with each intervention.

In addition, CMS should ensure practitioners are not required to bill lower-valued health coaching codes when the services provided meet the requirements for MNT or other recognized clinical services. CMS should continue to prioritize access to MNT delivered by RDNs for beneficiaries with nutrition-related chronic conditions, including diabetes, prediabetes, chronic kidney disease, hypertension, cardiovascular disease, overweight and obesity, cancer, dyslipidemia, COPD, HIV/AIDS, and malnutrition.

Finally, CMS should avoid policies that inadvertently equate clinical nutrition care with health coaching alone, as doing so could limit beneficiary access to the specialized nutrition interventions necessary to prevent, manage, and improve chronic disease outcomes. **We support the proposed health coaching benefit and encourage CMS to finalize the policy while preserving and strengthening access to MNT services furnished by RDNs.**

DIABETES SELF-MANAGEMENT TRAINING IN RURAL HEALTH CENTERS

The rule would recognize Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy as stand-alone billable services under the Rural Health Center all-inclusive Rate (AIR).

We encourage CMS to strengthen the DSMT benefit by removing the current one-year expiration on the initial 10 hours of DSMT. Beneficiaries often face barriers that delay completion of training, and eliminating this limitation would provide greater flexibility and help ensure patients receive the full benefit of the program.

CMS should also allow DSMT and MNT services to be furnished and billed on the same day. These services are complementary, not duplicative, and allowing same-day billing would support coordinated, patient-centered diabetes care while reducing unnecessary administrative barriers.

Finally, CMS should make telehealth reimbursement for DSMT permanent and permanently remove geographic and originating-site restrictions for both DSMT and MNT. Maintaining these flexibilities will preserve access to essential diabetes education and nutrition services, particularly for beneficiaries facing transportation, mobility, or provider access challenges.

GENERAL COMMENT ON MEDICAL NUTRITION THERAPY

Almost all Medicare beneficiaries live with at least one chronic condition, and more than 66% have multiple chronic conditions. Poor nutrition is a significant contributor to many of these diseases. **While the proposed rule recognizes nutrition as an underlying driver of chronic disease, it provides limited opportunities for beneficiaries to access evidence-based nutrition services from Registered Dietitian Nutritionists (RDNs) outside of Diabetes Self-Management Training (DSMT) and Shared Medical Appointments (SMAs).**

RDNs are the only healthcare professionals specifically trained and qualified to provide Medical Nutrition Therapy (MNT), an evidence-based intervention that uses the Nutrition Care Process to deliver individualized nutrition assessment, diagnosis, intervention, and ongoing monitoring. MNT helps prevent, delay, and manage disease while improving quality of life. In addition to clinical nutrition care, RDNs provide nutrition education and use behavior change techniques, including motivational interviewing, to support sustainable lifestyle improvements.

A substantial body of evidence demonstrates that MNT improves outcomes for numerous chronic conditions, including diabetes, prediabetes, obesity, hypertension, cardiovascular disease, chronic kidney disease, dyslipidemia, cancer, COPD, HIV/AIDS, and malnutrition. MNT has also been shown to reduce healthcare utilization and costs across multiple disease states.

Given the significant role nutrition plays in chronic disease prevention and management, efforts to improve beneficiary health outcomes should include expanded access to MNT services furnished by RDNs. **We urge CMS to expand coverage of MNT by allowing MNT CPT codes 97802, 97803, and 97804 to be used for a broader range of nutrition-related chronic conditions beyond the currently covered indications.** This change would improve access to evidence-based nutrition care, address a key driver of chronic disease, and support better health outcomes for Medicare beneficiaries.

340B DATA REPOSITORY

In the CY 2026 PFS rule, CMS stated it would establish a 340B claims repository to receive 340B covered entities' voluntary submissions of certain Medicare Part D claims data elements to test its usability in identifying which drug units were purchased under the 340B program. This claims data repository is slated to go live in fall 2026 with data testing to commence this summer. The agency now proposes to make data submissions to this 340B claims repository mandatory rather than voluntary and require all 340B covered entities to submit certain Part D claims data elements for drugs purchased under the 340B program to the repository starting Jan. 1, 2027.

Trinity Health is concerned about administrative burden on covered entities by requiring the submission of data that is largely duplicative of information already being reported through other mechanisms.

Requiring an additional reporting system adds complexity, increases operational costs, and diverts resources away from patient care without a clear demonstration that the new repository will provide meaningful information beyond what CMS already receives.

CMS recently finalized the 340B rebate model, which will require the collection and exchange of substantial claims-level data to support rebate administration and duplicate discount prevention. **Rather than creating a separate mandatory reporting requirement, CMS should leverage the data already being submitted through either the rebate model OR the 340B data repository.** Doing so would reduce unnecessary duplication, promote administrative efficiency, and minimize burden on covered entities.

If CMS finalizes making the data repository mandatory, we strongly recommend a phased-in approach. With the repository only going live in the Fall 2026, we believe that any changes for CY 2027 would be premature, preventing CMS and covered entities from learning from the initial rollout. **A phased in approach would allow CMS to assess data quality, identify operational challenges, refine technical specifications, and work collaboratively with stakeholders to improve reporting processes, particularly as CMS acknowledges the data requirements for the repository and rebate model overlap.**

REMOTE PATIENT AND THERAPY MONITORING

CMS proposes the following changes to remote patient monitoring (RPM) and remote therapy monitoring (RTM):

- The agency currently requires that RPM services be furnished only to an established patient, the rule would expand this established patient requirement to RTM services.
- CMS proposes that practitioners billing for RPM or RTM services must furnish a separately reportable initiating visit in association with the onset of these services, and that the services must be initiated by the billing practitioner during a face-to-face (in-person or telehealth) visit.
- The rule would allow payment for RPM and RTM services only when they are performed by clinical staff employed by the billing practitioner and not by a contractor.
- The rule proposes updates to the valuation of these services to reflect the potential reduced costs of the associated devices and seeks comments on bundling the RPM and RTM codes.

We oppose CMS's proposed restrictions on Remote Patient Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) services, particularly the proposal to require that these services be furnished only by clinical staff who are direct employees of the billing practitioner or practice. While we support CMS's goal of addressing program integrity concerns, this proposal represents a significant overreach into how providers and health systems choose to organize and deliver care and could disrupt clinically integrated remote monitoring programs and reduce beneficiary access to care. CMS itself recently expanded remote monitoring services and has approved hundreds of vendors and care delivery organizations that support providers in furnishing these services. Eliminating the ability to utilize contracted clinical support would unnecessarily disrupt established care models and reduce access to services that many patients rely on.

The proposal would limit flexibility, undermine team-based care models, and create operational challenges for practices that appropriately rely on third-party partners to support patient monitoring and engagement. Many providers, particularly those serving rural, underserved, or high-risk populations, do not have the resources to build and maintain large in-house monitoring teams. Restricting staffing arrangements could reduce participation in RPM and RTM programs and ultimately decrease patient access to clinically valuable monitoring services.

We are also concerned that CMS's proposal addresses program integrity concerns by restricting care delivery models rather than strengthening physician oversight and accountability. **A more balanced approach would be to reinforce the role of the primary care physician or other treating practitioner in authorizing and overseeing remote monitoring services. Regardless of who furnishes the day-to-day monitoring activities, CMS could require that the treating practitioner determine that remote monitoring is medically necessary, authorize the service, and remain responsible for ongoing clinical oversight.** This would ensure appropriate utilization while preserving provider flexibility and patient access.

In addition, CMS should not finalize the proposed policy to reduce PE inputs for RPM and RTM services through crosswalks to codes that do not accurately reflect the resources required to furnish remote monitoring services and would undervalue resources required to deliver these services. The proposed crosswalks create a false equivalency between RPM/RTM services and the comparison codes CMS selected. Unlike the services used for the crosswalk, remote monitoring often requires significant staff time to educate patients, troubleshoot technology, coordinate care, and travel to patients' homes to set up devices and ensure successful implementation. These activities create real practice expenses that are not adequately reflected in the alternative codes CMS proposes to use.

We urge CMS to retain the current PE methodology or provide additional evidence demonstrating that the proposed crosswalks accurately account for the full range of costs associated with remote monitoring services. The proposed reductions do not adequately reflect the real-world resources required to successfully furnish RPM and RTM and risk undermining beneficiary access to these important services.

BEHAVIORAL HEALTH

CMS proposes to establish separate coding and payment for shared medical appointments, which gather multiple patients with similar health conditions including behavioral health conditions. In addition, CMS would increase the work RVUs for smoking and tobacco use cessation and screening, brief intervention, and referral to treatment services.

We support this proposal, as tobacco use remains a leading preventable cause of chronic disease, and investing in early intervention can improve health outcomes while reducing downstream healthcare costs. Preventive services such as tobacco cessation counseling illustrate that timely support and intervention today can prevent far more serious and costly health complications in the future. Appropriately valuing these services recognizes the important clinical work required to help patients achieve lasting behavior change and supports Medicare's broader goals of prevention and chronic disease management.

MEDICARE SHARED SAVINGS PROGRAM

Financial Methodology

Accountable Care Prospective Trend

Trinity Health appreciates CMS's recognition that the Accountable Care Prospective Trend needs to be modified. While the ACPT methodology was well-intended, it has unintentionally reduced ACO benchmarks, making it more difficult for ACOs to achieve shared savings. Accordingly, **Trinity Health welcomes the proposed guardrail policy, retroactive to PY 2025**, as an important step toward providing greater predictability and protection for ACOs. We also support CMS's proposal to calculate annualized growth rates for each performance year rather than on an agreement-period basis. While these proposed changes represent meaningful progress, **we urge CMS to consider additional modifications to mitigate the ratchet effect that occurs when ACOs successfully lower expenditures during an agreement period** such as the examples referenced in the next section.

Risk Adjust 5% Cap

Trinity Health supports CMS's proposal to risk adjust the 5 percent cap on upward adjustments to the historical benchmark. This proposed change would better account for ACOs serving medically complex populations and may encourage participation by organizations that care for higher-acuity beneficiaries. However, we urge CMS to ensure that this policy does not negatively impact ACOs – meaning CMS should not risk adjust the 5 percent cap below 1.0.

In addition to risk adjusting the cap, **Trinity Health encourages CMS to increase the cap on upward adjustments to the historical benchmark.** The historical benchmark adjustments were put in place to mitigate the benchmark ratchet effect; however, under current policy, the combined five percent cap on upward benchmark adjustments limits an ACO's ability to realize the full value of the efficiencies it generates through sustained participation in MSSP over time. As ACOs become more successful and efficient, their benchmarks become progressively less reflective of the resources needed to sustain and expand those improvements, let alone expand them. Rather than raising the cap to a single, standard rate for all ACOs, CMS could consider tiering or prorating the cap based on an ACO's length of participation and demonstrated savings performance. ACOs that have participated in the Shared Savings Program across multiple agreement periods and generated sustained savings have fewer remaining opportunities to achieve additional spending reductions. Maintaining the current cap may therefore weaken incentives for continued participation. **A higher, appropriately structured cap would better recognize demonstrated performance, reduce the ratchet effect, and preserve incentives for long-term participation in the program.**

ENHANCED Track Positive Regional Adjustment

Trinity Health is concerned by CMS's proposal to reduce the maximum weight of the positive regional adjustment from 50% to 35% for ENHANCED Track ACOs. This reduction would disadvantage efficient ACOs by diminishing recognition of lower-cost performance; this appears inconsistent with the program's objective of encouraging providers to assume greater risk while improving cost management for Medicare beneficiaries. Because participation in higher-risk arrangements requires significant operational discipline to become cost efficient, this policy could discourage high-performing, efficient ACOs from continuing in the ENHANCED Track. **We urge CMS to retain the maximum weight of the positive regional adjustment at 50% for ENHANCED Track ACOs.**

Prior Savings Adjustment

Trinity Health supports CMS's proposal to increase the prior savings adjustment scaling factor from 50% to 75%. ACOs that have consistently reduced costs year over year are adversely affected by rebasing and ratcheting effects as they continue participation in the model. Increasing the prior savings adjustment scaling factor would better recognize prior performance and provide more incentive for ACOs to generate and sustain savings over time.

Growth Adjustment

Trinity Health supports policies that promote continued growth and participation in the Shared Savings Program, including CMS's proposal to add a growth adjustment to the historical benchmark. This adjustment would better recognize ACOs that invest in broader provider recruitment and engagement activities and expand beneficiary attribution. CMS should consider removing limits on which beneficiaries count toward the growth adjustment and instead **should count all net new beneficiary growth toward the growth adjustment,** regardless of whether the beneficiary is attributed to a new or existing ACO professional or has prior Shared Savings Program attribution.

Level E Shared Savings Rate.

Trinity Health supports the proposed change to increase the shared savings rate for BASIC Track Level E from 50% to 60%.

Quality

Data Completeness

Trinity Health appreciates and applauds CMS's recognition of the need to revise Shared Savings Program quality reporting data completeness requirements beginning in PY 2026. Despite ACOs' diligent efforts to comply, circumstances beyond their control can impede complete reporting. For example, some CEHRT vendors are unable or unwilling to support all required quality measures, and unexpected practice closures can make it impossible to obtain QRDA I files needed for reporting. While we strongly support the proposed flexibilities, **we ask CMS to broaden the exclusion category beyond "specialty-focused" EHR vendors to include any EHR vendor that is unable or unwilling to support specific required measures.** We also ask CMS to **clearly define the scope of "other circumstances as determined by CMS" and establish a transparent process for ACOs to request exclusions under this category.** While we welcome CMS's proposed flexibility, we believe the 95% reporting threshold remains too high, given the operational realities of multi-EMR ACOs and the challenges faced by small, independent practices. **We urge CMS to adopt a 90% assigned-beneficiary reporting threshold,** which would better balance accountability with the practical limitations. ACOs should not face penalties for factors outside their control.

CEHRT Requirements

Trinity Health appreciates and strongly supports CMS's proposal to simplify the CEHRT requirement by replacing the current Promoting Interoperability reporting requirements for ACOs. In previous comment letters, we have highlighted growing provider concerns regarding the cumulative administrative and financial burdens associated with participation in the Medicare Shared Savings Program, particularly concerning the addition of mandatory Promoting Interoperability requirements alongside electronic clinical quality measure (eCQM) reporting. Because eCQM reporting already necessitates the use of CEHRT, the Promoting Interoperability requirements have often been viewed as duplicative and burdensome. We believe this proposed change represents a meaningful step toward reducing an unnecessary burden on both providers and ACOs, allowing them to devote greater resources and attention to improving care delivery and achieving better outcomes for Medicare beneficiaries.

App Plus Measure Set

Trinity Health supports the proposal to simplify the APP Plus Measure Set by removing the Initiation and Engagement of Substance Use Disorder Treatment and Adult Immunization Status measures beginning in PY2027. As organizations transition to eCQM reporting, many CEHRT EMR vendors continue to struggle to fully support current measure requirements, including the Breast Cancer Screening measure. Adding new measures before these reporting capabilities are consistently available would likely exacerbate existing gaps and increase operational complexity. In addition, eCQM reporting has required substantial provider education and workflow redesign to ensure accurate documentation in the appropriate EMR fields. Excluding these two additional measures will help reduce administrative burden on providers and support a more manageable and effective transition to electronic quality reporting.

Reporting Options

Trinity Health supports CMS's proposal to extend the MIPS CQM reporting option and establish a new Medicare eCQM reporting option, as these proposals would provide ACOs with flexibility to select the reporting approach that best aligns with their operational capabilities and unique circumstances. Trinity Health is intrigued by the Medicare eCQM reporting option because it may more accurately represent the quality of care delivered to attributed Medicare beneficiaries. However, we have technical feasibility concerns especially for multi-EMR ACOs, as QRDA I files are designed to capture all patients and all payers that meet measure specifications, and

there is not a way to filter to a defined population. Each EMR instance would need the functionality to identify assigned beneficiaries when generating QRDA I files for this to be a practical reporting option for ACOs. We encourage CMS to work with CEHRT EHR vendors to determine a pathway to support Medicare eQMs. Trinity Health supports the proposal provided that eQM remains a reporting option.

Beneficiary Engagement Policies

Beneficiary Notification

Trinity Health appreciates and strongly supports CMS's proposed revisions to the beneficiary notification requirements. This includes replacing the current requirement to provide notice at a beneficiary's first primary care visit with a standardized deadline of May 30, as well as eliminating the follow-up communication requirement. These changes represent a significant step toward reducing unnecessary administrative complexity and compliance burden for both ACOs and participating practices. By simplifying the notification process, CMS will enable organizations to dedicate more resources to care coordination, beneficiary engagement, and activities that directly support improved health outcomes, while maintaining transparency and beneficiary awareness of ACO participation.

Part B Cost Sharing

Trinity Health supports CMS's proposal to allow ACOs to reduce or eliminate Part B cost-sharing obligations, as this flexibility would better align the Shared Savings Program with other CMMI models and could help reduce financial barriers to beneficiary access to care. To support successful ACO implementation and update, CMS should ensure the program's administrative requirements are not overly burdensome.

QUALITY PAYMENT PROGRAM

Advanced APMs

QP Determination

Trinity Health supports CMS's proposal, pursuant to the Consolidated Appropriations Act, 2026, to lower QP thresholds for performance year 2026 to 50% payment amount and 35% patient count. However, we strongly urge CMS to maintain these thresholds beyond 2026 to expand clinicians' ability to qualify as QPs and receive incentives for participation in Advanced APMs. **Trinity Health strongly encourages CMS to retain the lower thresholds and permanently extend the Advanced APM bonus, as this payment is one of the strongest incentives for encouraging provider participation in Advanced APMs.**

Trinity Health opposes CMS's proposal to make QP and Partial QP determinations at the TIN/NPI level, including limiting MIPS exemptions to only the TIN(s) through which a clinician meets QP or Partial QP status. Physicians frequently bill under multiple TINs. Under the proposed policy, providers would retain the Advanced APM bonus and/or QP conversion factor and MIPS exemption only for services billed through the ACO TIN, while facing potential payment reductions and additional MIPS reporting obligations for the same quality of care delivered under other TINs.

Additionally, CMS's proposal raises important questions about whether making QP and Partial QP determinations at the TIN/NPI level is consistent with MACRA. MACRA frames QP status as an attribute of the eligible professional, not of a specific billing relationship. Section 1833(z)(2) of the Social Security Act defines a "qualifying APM participant" as an "eligible professional" who meets the applicable participation threshold. Similarly, section 1848(q)(1)(C)(ii) excludes an eligible professional who "is a qualifying APM participant" from the definition of a MIPS eligible professional. Neither provision contemplates separate QP determinations based on each TIN through which a clinician furnishes services.

Applying QP determinations at the TIN/NPI level would substantially weaken one of the most important individual-level incentives for clinicians to participate in Advanced APMs. It would also make Advanced APM participation less attractive and more administratively burdensome for clinicians who practice across multiple sites or bill under multiple TINs, thereby undermining CMS's broader goal of expanding participation in value-based care.

Transition to MVPs

Trinity Health appreciates CMS's effort to establish a clear timeline for transitioning from MIPS to MVPs, as the timing and sequencing of this transition have remained uncertain. A defined timeline gives organizations an important framework to plan for the operational, technical, and reporting changes necessary for successful implementation. **However, we continue to have significant, ongoing concerns regarding the transition to MVPs, particularly if implementation proceeds before the necessary measure infrastructure and specialty-specific pathways are fully developed.**

First, as mentioned in prior comment letters, we remain deeply concerned that mandatory MVP reporting for specialists, particularly those already participating in ACOs or Advanced APM arrangements, would create duplicative requirements and unnecessary administrative burden. Providers participating in ACOs are already accountable for cost and quality performance; imposing mandatory MVP reporting on these clinicians would weaken the incentive for specialty participation in ACOs and other Advanced APMs. **Accordingly, Trinity Health strongly urges CMS to exempt ACO-participating providers from mandatory MVP reporting requirements.**

Additionally, developing all the MVPs within the EMR needed to support all specialty reporting will require substantial time and resources to complete. **We suggest that CMS make the following two adjustments to the proposed policy to ensure the success of MVPs and dQMs:**

1. Stagger the transition to digital quality measures (dQMs) and the transition from MIPS to required MVPs, so that we can **focus first on a successful transition to dQMs.**
2. **Ensure that sufficient dQMs are available for all specialties that will be required to report** through the Ambulatory Specialty Model (ASM) or a MIPS Value Pathway (MVP).

AMBULATORY SPECIALTY MODEL

Trinity Health firmly believes the solution to addressing high health care costs in the U.S. while improving patient health outcomes is value-based payment, including holding providers accountable for the total cost of care, rather than reimbursing based on volume, and we appreciate CMS's continued focus on specialist integration in value-based care, as it is critical to improving access to high-quality care at lower costs. However, we still have significant concerns that the Ambulatory Specialty Model, as currently designed, will create duplicative requirements, increase administrative burden, and undermine participation in existing Advanced APMs.

We strongly urge CMS to exclude ACO-participating clinicians from mandatory ASM participation as many ACOs are already actively managing populations that include the very same conditions that would be targeted in the model. Requiring specialists in an ACO to participate will exponentially increase administrative burden, create duplicative reporting requirements, and more importantly, unintentionally discourage specialists from remaining in and joining advanced APM arrangements. **At minimum, clinicians with QP or Partial QP status should be excluded from ASM or permitted to opt-in voluntarily.**

Furthermore, **Trinity Health strongly urges CMS to delay implementation of the Ambulatory Specialty Model by at least one year until 2028.** At this stage, CMS has not provided all the measure specifications, benchmarks, operational guidance, or other critical implementation details necessary for providers to evaluate the model's feasibility or prepare for successful participation. In addition, clinicians do not yet know whether they will be selected for mandatory participation, leaving insufficient time to assess impact, coordinate with EMR vendors, update workflows, educate providers, and align reporting infrastructure. Moving forward under these circumstances would create unnecessary operational burden and risk undermining the model's goals. **A one-year delay is necessary to ensure that the model can be implemented in a manner that is fair, transparent, and operationally sound.**

ASM Eligibility

Health opposes CMS's proposal to specify that once a clinician is selected for ASM participation for at least one performance year, the clinician would remain in the model for the duration of the test period unless CMS terminates the model or the participant's participation. We urge CMS to refine this policy to ensure that continued participation remains appropriate, measurable, and operationally sound over time. Specifically, CMS should:

- Allow clinicians to exit the model if their attributed episode volume falls below the eligibility threshold, since low-volume participation may not support reliable performance measurement
- Increase the initial eligibility threshold to at least 100 attributed episodes during the two-year baseline period and **require at least 50 episodes during the performance year to reduce statistical variation and ensure performance results are based on a sufficient number of cases.** This also ensures that selected clinicians are more likely to maintain a meaningful attributed episode volume throughout the model test period, reducing participant churn and improving the stability and validity of the model population.

Redesignated Specialty Types

Trinity supports CMS's proposal to establish a process for ASM Heart Failure Cohort participants to redesignate their subspecialty and receive an exemption from the model. We encourage CMS to adopt a similar policy for the Low Back Pain Cohort as well.

Data Submissions

Trinity supports CMS's proposal to allow improvement activity data to be submitted at either the individual or group level. While we support this proposal, **we recommend CMS extend this same flexibility to all ASM performance categories, consistent with MIPS, so clinicians may report at the individual or group level** and leverage existing workflows and reporting processes. In general, mandating model participation at the individual NPI level, as required under ASM, makes it difficult for practices to support team-based care and maintain standardized workflows when only one or two providers within a practice are selected for participation. This approach creates separate operational workflows and imposes significant administrative and reporting burden, particularly when some providers within the same practice must report under MIPS while others are required to report under ASM.

Quality Measurement

Trinity Health does not support adding the MRI Lumbar Spine measure until CMS publicly releases measure specifications, testing results, and other supporting information necessary for clinicians and stakeholders to assess whether the revised measure is reliable, valid, and actionable for performance

improvement. All baseline historical performance data for selected providers should be made available prior to the model start date.

Trinity Health supports CMS's proposal to offer a quality performance category incentive for the voluntary submission of patient-reported outcome (PRO) data. However, **we urge CMS to keep the PRO data submission voluntary on a permanent basis** given the significant administrative burden associated with PRO data collection and reporting and the ongoing concerns regarding reliability and usefulness for driving meaningful performance improvement.

Trinity Health supports removing the Functional Status Change for Patients with Low Back Impairments measure (MIPS Q220). However, we oppose replacing it with another measure that is only supported by the MIPS CQM collection type. Because not all EMR vendors support both eCQM and MIPS CQM collection types, the proposed replacement measure, MIPS Q182 would require clinicians to rely on registry reporting, adding unnecessary financial and administrative burden to participation in the model. **Trinity Health urges CMS to only select measures supported by either claims or by both eCQM and MIPS CQM so that all selected providers have a fair and feasible opportunity to report quality performance.**

ALTERNATIVE PAYMENT MODEL REQUEST FOR INFORMATION

Transition to FHIR-based dQMs

Trinity Health generally supports CMS's proposed transition to digital quality measures (dQMs), as we anticipate this evolution can ultimately reduce administrative burden, decrease manual reporting, and lower costs associated with annual quality reporting. **While we support the underlying objectives of an eventual transition to dQMs, we have significant concerns regarding several aspects of the proposed approach that warrant further consideration, including the timing of the transition.**

To make this transition successfully, Trinity Health requires technical details from CMS on the use of self-contained measure calculation tools (MCTs) and how those will be deployed/used. We also look forward to CMS' guidance on the mechanics of data aggregation for dQMs. The *Digital Quality Measurement Strategic Roadmap* CMS published in March 2022 includes the agency's vision for modernizing data aggregation for quality reporting; however, it remains unclear as to the specific roles and alignment of Focused (e.g. EHR) vs Broad (e.g. HIE) data aggregators in the dQM strategy.

Once CMS shares the MCT and data aggregation technical requirements/options, Trinity Health recommends a multi-year pilot program to allow for implementation and testing of the entire dQM strategy, inclusive of the MCT and data aggregation elements. Such a multi-year strategy would allow health systems to effectively plan, test, and resource this effort. Trinity Health welcomes the opportunity to partner with CMS, ONC, and NAACOS on such a strategy.

To further support these important changes in quality reporting methodology, Trinity Health encourages CMS to add the following provisions to CEHRT requirements:

- EHR must support all measures required by CMS for ACOs
- EHR must be able to successfully deliver data required for ACO quality reporting (via methodologies recommended/required by CMS)
- EHR vendor must commit to a CMS-defined deadline for releasing annual measure updates (note: *installation of those updates will be the responsibility of the EHR customer*)

Additional questions related to dQM strategy are as follows:

- What reporting, real-time or otherwise, will be available from CMS on an ACO's quality performance based on data collected by CMS via FHIR APIs?
- What will dQMs do to assist with data ingestion from independent affiliates in health system-based ACOs? Sounds like Trinity Health will continue to have the burden of ingesting data practice-by-practice under the dQM model, which is a major technical and administrative burden.
- How will CMS align dQM-related data collection with source systems' (e.g. EHR) deployment of updated quality measure specifications each year? Often, EHR vendors do not make those system updates available until at least mid-calendar year.
- How will CMS align the delivery of updated dQM quality measure specifications with updates required to the USCDI+?

Establishing Prospective Primary Care Payments in MSSP

Trinity Health supports the inclusion of prospective payments within MSSP as this will create more alignment between MSSP and other CMMI models such as LEAD. Additionally, offering prospective payments often minimizes cash flow challenges and allows practices and ACOs to invest in services and innovation ahead of receiving shared savings.

To start, the inclusion of prospective payment arrangements in MSSP should be optional for ACOs to elect rather than mandatory as not all ACOs and practices are ready to adopt this type of payment arrangement. We recommend offering ACOs both primary care capitation and hybrid payment options that shift the underlying payment mechanism away from fee-for-service. CMS should build on the prospective payment experience gained through ACO REACH and ACO Primary Care Flex (PC Flex) and incorporate similar optional arrangements into MSSP. Trinity Health recommends eliminating the low-revenue ACO eligibility limitation in PC Flex and making prospective payment options available to high-revenue ACOs as well.

We also recommend reducing the administrative burden and operational limitations associated with PC Flex, including requirements to develop quarterly and annual spend plans, submit modification requests when funds are allocated differently than initially projected, and publicly report detailed spend plan information. Public reporting should be simplified to indicate only whether an ACO has elected to participate in prospective payments. Streamlining these requirements would reduce unnecessary burden, improve operational flexibility, and support broader adoption of prospective payment arrangements within MSSP.

Specialty Care in MSSP

Trinity Health supports the integration of specialty care into value-based care. We encourage CMS to prioritize meaningful pathways and opportunities for specialist participation in ACOs and other total cost of care arrangements rather than implementing fragmented, mandatory specialty models. CMS should also address existing policies that may discourage specialists from participating in accountable care arrangements either

- Allow MSSP ACOs to designate non-physician practitioners as either primary care or non-primary care clinicians, consistent with the LEAD ACO model.
- Create separate benchmarking approaches and concurrent risk coding to keep up with innovations within the specialty

Applying Electronic Prior Authorization Measures to MSSP

CMS seeks feedback on potentially requiring the use of specific FHIR-enabled Health IT Modules within CEHRT to complete at least one prior authorization request and determination for at least one medical item or service during the performance period or allowing it to be an option for meeting Shared Savings Program CEHRT use requirements beginning with the CY 2028 performance year. **Trinity Health supports this as an option for meeting CEHRT the requirement as long as the other proposed options remain.**

CMS also seeks feedback on creating a new, ACO-specific electronic prior authorization measure to require use of specific FHIR-enabled health IT modules within CEHRT to complete at least one prior authorization request and determination for at least one prescription drug during the performance period, beginning with the CY 2028 performance year. **Trinity Health does not support and strongly recommends that any new FHIR-based requirements in MSSP should align with the broader transition to FHIR-based requirements across CMS programs.**

PRIMARY CARE REQUEST FOR INFORMATION

- I. **What updates to the HCPCS code G2211 policy (or the proposed modifiers, MOD1 and MOD2) should CMS consider to ensure the clinician billing HCPCS code G2211 (or proposed modifiers, MOD1 and MOD2) is serving as the focal point for beneficiaries, and that the practitioner is also considering preventive care, risk factor reduction, and other services necessary for coordinating the care of beneficiaries who have a complex condition?**

We appreciate CMS's continued efforts to address real challenges facing primary care and to recognize the value of the longitudinal relationships primary care providers maintain with their patients. We strongly support policies that increase reimbursement for primary care and better account for the ongoing work involved in managing complex patients over time. However, any payment reform should keep the primary care physician-patient relationship at the center of the model and ensure that reimbursement appropriately reflects the accountability, coordination, and continuity of care that primary care providers deliver.

CMS's current approach relies heavily on creating additional billing codes and payment adjustments to capture complexity. While well-intended, this risks making the Medicare payment system increasingly complicated for providers and CMS itself. The evolution of G2211 is a good example. What began as a mechanism to recognize the longitudinal nature of primary care has expanded beyond primary care. While there may be justification for extending G2211 to a limited number of specialties with ongoing relationships and significant care coordination responsibilities, such as oncology and cardiology, CMS should remain focused on supporting true longitudinal care management.

Rather than adding a growing number of complexity-related, condition-specific, or service-specific codes, CMS should consider a simpler and more sustainable approach. If the goal is to better compensate primary care providers for managing increasingly complex patient populations, payment should be tied to the complexity of the provider's patient panel. CMS already has the data necessary and experience using risk adjustment methodologies and could leverage those tools to stratify primary care payment based on the complexity of the beneficiaries they serve.

We recommend CMS establish a primary care complexity adjustment whereby providers receive an enhanced payment rate for all E/M services based on the risk profile and complexity of their patient panel. A practice managing a highly complex population could receive a percentage increase across E/M services, eliminating the

need for providers to navigate numerous add-on codes and documentation requirements. This approach would better align payment with the reality of longitudinal care while reducing administrative burden.

- II. Given the broad range of changes CPT makes annually, we recognize updates to the CPT code set to reflect distinctions among O/O E/M visits by the function of the visit (longitudinal, acute, or consultative) may have significant advantages within the current billing and coding ecosystem. However, absent a change in CPT coding, should we consider the possibility of creating G codes to better recognize distinction between and among these kinds of visits? If so, what categories should we consider? How could we effectively differentiate longitudinal care visits from acute care visits? What number of levels would be needed and for which settings of care? Should we use existing CPT codes as templates? How should we consider valuing these potential G-codes under the PFS, including the basis for the standard inputs: work RVUs, time values, specialty mix for utilization crosswalks, direct PE inputs, etc.? How would practitioners balance and manage the increasing number and complexity of these codes?**

Again, we caution CMS about the continued layering of new codes and payment policies onto the Physician Fee Schedule for primary care. While condition-specific bundles may eventually have a role for conditions such as osteoarthritis, hypertension, or diabetes, these models become increasingly difficult to administer when patients have multiple chronic conditions, and where the care for these conditions is shared among multiple providers. CMS should be cautious about creating an ever-expanding array of codes, bundles, and payment adjustments that create complexity without meaningfully improving care delivery. Per our comment above, CMS should focus on establishing a G code that provides a primary care provider a payment increase based on the complexity of their patient panel.

III. Other Comments

We urge CMS to provide greater flexibility for Accountable Care Organizations (ACOs) to implement prospective, capitated primary care payment models similar to those available through the LEAD model. Primary care providers are responsible for managing increasingly complex patient populations and would benefit from payment approaches that better support proactive, longitudinal care rather than relying solely on fee-for-service reimbursement.

CMS could leverage existing risk adjustment methodologies to establish prospective payments based on the complexity of a provider's patient panel, ensuring that payments more accurately reflect the resources required to care for beneficiaries with greater clinical needs. Providing a predictable, risk-adjusted payment stream would improve cash flow for primary care practices participating in ACOs, enabling greater investment in care coordination, population health management, and team-based care.

Importantly, any prospective payment option should be designed with minimal administrative burden and limited reporting requirements. CMS should avoid adding unnecessary operational complexity and instead provide ACOs and primary care providers with a flexible, streamlined payment approach that supports accountability while allowing clinicians to focus on patient care.

We believe expanding access to risk-adjusted prospective primary care payments within ACOs would strengthen primary care, improve care delivery, and better align Medicare payment with the goals of value-based care.

In addition, primary care providers should receive equitable payment increases regardless of whether they practice independently or within a health system. The value of primary care is driven by the services provided, including longitudinal patient relationships, chronic disease management, care coordination, and preventive care, not by the provider's organizational structure.

Health system-employed/affiliated primary care physicians care for the same Medicare beneficiaries, manage the same complex conditions, and are held accountable for the same quality and outcome expectations as independent practitioners. Excluding or limiting payment increases based on practice affiliation would create unnecessary disparities and undermine CMS's goal of strengthening primary care capacity across the healthcare system.

We encourage CMS to ensure that any primary care payment enhancements are applied consistently across practice settings so that all primary care providers are appropriately supported in delivering high-quality, coordinated, and patient-centered care.

COMMUNITY-BASED PALLIATIVE CARE REQUEST FOR INFORMATION

Trinity Health applauds CMS for its initiative in further developing how to improve the delivery of palliative care. Evidence shows that palliative care improves quality of life, reduces symptom burden, supports and honors patients through their disease trajectory and can prolong life at times as well as reduce caregiver and clinician burden. In doing so, palliative care can steward our resources and help avoid unwanted/unnecessary interventions.

Palliative care must be led by specialty trained physicians, managed by interdisciplinary teams including APP's, RN's, social workers, pharmacist, chaplains and allied health professionals. Benefits of palliative care include improved symptom management, evaluation of benefits/burdens of ongoing medical care/interventions, delineation of goals of care and treatment preferences and end of life planning. In doing so, the goal is to anticipate crisis, plan for a response and be prepared to support the patient where they want to be. This can lead to reduction of unnecessary hospitalizations, reduction in ED visits and improved quality of life.

Generally, CMS should further clarify the distinction between hospice care and palliative care. While palliative care can be delivered concurrently with disease-directed treatment, hospice represents a transition away from disease directed interventions to comfort and quality of life care. Many patients delay receiving palliative care because they mistakenly believe that palliative care requires them to forgo curative or disease-modifying therapies.

Fraud and abuse

Where should CMS focus on potential fraud, waste, and abuse in community-based palliative care?

Through our own work in palliative care and tracking through our ACOs, Trinity Health believes there is no significant fraud and abuse of palliative care. Opportunities for improvement do exist when patients have stabilized with good symptom management and disease progression and may be eligible for de-escalation of palliative care visits.

The most effective way to prevent fraud and abuse is for CMS to establish graduated levels of palliative care eligibility, along with corresponding expectations for the frequency and intensity of services. At the same time, CMS should avoid overly prescriptive requirements and preserve the flexibility needed for physician-led, multidisciplinary palliative care teams to exercise clinical judgment based on individual patient needs. One

approach CMS could consider is the stratified red/yellow/green risk framework developed by the Camden Coalition of Healthcare Providers, which was adapted from the Center to Advance Palliative Care (CAPC).

Risk level	High	Medium	Low
Care intensity	Visits 2+ month and phone/video calls 2+/month	Visits 1/ month and phone/video call 1/month	Visits every 2 months and phone/video calls 1/month
Utilization	2	1	None
ADL	Dependence in 1+ new ADL in past 3 months	Some functional impairment	Minimal or no functional impairment
Palliative Performance Score	PPS <=40	PPS <=60	Normal function
Medical	Advanced illness or multiple chronic conditions AND significant deterioration in clinical status	Advanced illness or multiple chronic conditions	Advanced illness or multiple chronic conditions
Psychosocial	Lives alone or high caregiver burden or financial distress or remote rural location	Lives with caregiver or good support network	Lives with caregiver and good support network

Eligibility for serious illness care

For any future supportive or palliative care service for Medicare beneficiaries, should eligibility be restricted to certification of a likely life expectancy duration?

Defining a specific life expectancy threshold for palliative care eligibility is challenging because patients' needs, disease trajectories, and duration of illness can vary significantly. However, leaving eligibility entirely open-ended could inadvertently result in palliative care providers managing chronic conditions that are not associated with a terminal prognosis, which is beyond the intended scope of the program. If CMS elects to limit eligibility to beneficiaries with a terminal prognosis, Trinity Health recommends defining eligibility based on an anticipated life expectancy of up to two years, coupled with active symptom burden, complex medical needs, or a need for goals-of-care discussions and decision-making support related to the underlying illness.

Below are examples of disease-specific criteria for CMS to consider:

- Cancer: Advanced disease for which treatment is no longer being pursued with curative intent
- Congestive Heart Failure (CHF): Stage III or IV disease, particularly for patients with recurrent hospitalizations or those considering advanced therapies.
- Chronic Obstructive Pulmonary Disease (COPD), Emphysema, or Pulmonary Fibrosis: Recurrent hospitalizations, escalating oxygen requirements, worsening dyspnea, or consideration of lung transplantation.
- Renal Failure (Stage IV/V): Patients approaching decisions regarding dialysis initiation, or patients with ESRD who are evaluating whether to discontinue dialysis.
- Decompensated Cirrhosis: MELD score greater than 19, recurrent ascites, or frequent hospitalizations.
- Dementia or Parkinson's Disease: Progressive functional or nutritional decline, increasing care needs, or recurrent hospitalizations.

Eligibility for palliative services

For any future supportive or palliative care service for Medicare beneficiaries, how could we consider impact on the daily functions of life or activities of daily living as part of who is eligible for the service?

The impact of a patient's condition on activities of daily living (ADLs) or functional status should not be used as a determining factor for palliative care eligibility because functional decline is not a reliable indicator of palliative care need. Patients often experience significant symptom burden, complex care coordination needs, and challenging treatment decisions while remaining largely independent in their daily activities. Requiring functional impairment as a condition of eligibility could delay access to supportive services until later stages of illness, contrary to the goal of providing timely, patient-centered palliative care. Instead, eligibility should be based on factors such as serious illness, prognosis, symptom burden, and the need for care planning and decision-making support.

Would eligibility best be based on impact on daily function, on caregiver strain, or both?

While frequency of visits and how often a patient needs interventions/supports may be based on impact on daily function and caregiver strain, eligibility should be based on disease and life expectancy.

How can we avoid overly burdensome requirements for defining eligibility for services?

CMS can avoid overly burdensome eligibility requirements by establishing broad, clinically meaningful eligibility parameters while preserving flexibility for provider-led interdisciplinary palliative care teams to exercise clinical judgment based on individual patient needs. CMS should avoid overly prescriptive criteria that rely on rigid diagnoses, prognostic thresholds, or extensive documentation requirements, as these approaches may create unnecessary administrative burden and delay access to clinically appropriate care.

Trinity Health supports the eligibility standards developed by the [Center to Advance Palliative Care](#) (CAPC), which recognizes that palliative care eligibility should be based on a patient's needs related to a serious illness rather than prognosis alone. This approach allows providers to identify patients who would benefit from palliative care services without requiring beneficiaries to meet narrowly defined clinical benchmarks.

Patients with a serious illness should be considered eligible for palliative care when they have one or more indicators of unmet symptom management, psychosocial, functional, caregiver, or decision-making needs. Examples include:

- A new diagnosis of a life-limiting illness
- Progressive functional decline or declining ability to perform activities of daily living
- Unintentional weight loss.
- Consideration of high risk surgery
- Two or more hospitalizations within three months.
- Difficult-to-control physical or emotional symptoms related to the serious illness.
- Uncertainty regarding prognosis or treatment options.
- Goals-of-care conflicts or complex treatment decisions.
- Questions about artificial nutrition/hydration.
- Limited caregiver or social support.

- Psychological, spiritual, or existential distress related to serious illness.
- Questions regarding hospice appropriateness.

Future of care management services

How should we differentiate the care management requirements for seriously ill beneficiaries from other Medicare beneficiaries?

CMS should differentiate the care management requirements for seriously ill beneficiaries from those applicable to the broader Medicare population by recognizing the unique clinical, psychosocial, and care coordination needs associated with serious illness. Unlike traditional care management programs, palliative care serves beneficiaries with complex symptom burden, multiple chronic conditions, frequent care transitions, and challenging medical decision-making needs that require a more comprehensive, interdisciplinary approach.

CMS should avoid simply layering additional documentation, reporting, or administrative requirements onto existing care management programs. Instead, requirements should be tailored to the goals of palliative care and focus on outcomes that matter to patients and families, such as symptom relief, goal-concordant care, improved care coordination, and reduced avoidable hospital utilization.

What are the essential service elements that must be included? For example(s), continuity with a designated team member, access to timely clinical support, comprehensive symptom and caregiver assessment, electronic care plans, coordination with treating physicians, patient/caregiver education, timely follow up after ED/discharge. What other service elements should be included? Should any not be included?

Palliative care is not a care management service, but rather an interdisciplinary team relying on specialty expertise to treat the patient as a whole. As CMS considers the essential service elements of a palliative care benefit, requirements should reflect the comprehensive, patient-centered nature of palliative care and avoid reducing it to a traditional care management model.

Trinity Health believes that the essential service elements for a Medicare palliative care benefit should focus on delivering interdisciplinary care that addresses the physical, emotional, psychosocial, spiritual, and decision-making needs of individuals with serious illness. CMS should establish core service requirements while maintaining flexibility for provider-led teams to tailor services based on patient needs, goals, and disease trajectory.

At a minimum, the following service elements should be included:

- Comprehensive assessment of the patient's physical symptoms, psychosocial needs, spiritual concerns, caregiver needs, medical history, prognosis, and goals of care.
- Expert symptom management for pain, dyspnea, fatigue, nausea, anxiety, depression, and other distressing symptoms associated with serious illness.
- Advance care planning and goals-of-care discussions to ensure treatment decisions align with the patient's values, preferences, and desired outcomes.
- Care coordination across providers and settings, including communication with primary care physicians, specialists, hospitals, post-acute providers, hospice organizations, and community-based services.

- Continuity of care through a designated interdisciplinary team member who serves as a consistent point of contact for patients and caregivers.
- Timely access to clinical support to address symptom exacerbations and urgent needs that may otherwise result in avoidable emergency department visits or hospitalizations.
- Patient and caregiver education regarding disease progression, treatment options, symptom management, advance care planning, and available support services.
- Caregiver assessment and support, recognizing the critical role caregivers play in helping patients navigate serious illness.
- Timely follow-up after emergency department visits, hospitalizations, or significant clinical changes to support safe transitions and continuity of care.
- A shared care plan, preferably electronic when feasible, that documents patient goals, treatment preferences, symptom management plans, and key care coordination activities.

In addition, Trinity Health recommends including:

- Psychosocial, behavioral health, and spiritual care services, either directly or through referral.
- Medication review and management, particularly for patients with complex medication regimens and multiple chronic conditions.
- Assessment and intervention related to social determinants of health, including transportation, housing, food insecurity, and caregiver support needs.
- Hospice education and transition support, when clinically appropriate.
- Regular reassessment of patient symptoms, goals, and care needs, recognizing that serious illness trajectories change over time.

CMS should avoid requiring overly prescriptive operational standards, such as rigid staffing requirements, mandatory team compositions, or fixed visit frequencies. These requirements could undermine the flexibility necessary for interdisciplinary palliative care teams to respond to individual patient needs and may create unnecessary administrative burden without improving quality. Instead, CMS should focus on the core capabilities and outcomes of high-quality palliative care while allowing providers the flexibility to determine how best to deliver those services.

Advanced primary care management

- Should care management services for seriously ill beneficiaries also require reporting to a MIPS Value Pathway? Which quality measures should be reasonably included?
- If no viable MIPS Value Pathway reporting mechanism is found, what are the essential quality elements required for palliative care management? Is sole reporting of ambulatory palliative care patients feeling heard and understood (CBE 3665) sufficient? Should other measures be considered?

Palliative care is fundamentally different from traditional episodic medical care and is best supported through a per-member-per-month (PMPM) payment model rather than fee-for-service reimbursement. A PMPM approach recognizes the ongoing, longitudinal nature of palliative care and provides the flexibility necessary to deliver comprehensive, patient-centered services that improve quality of life for individuals with serious illness.

Supports Interdisciplinary Team-Based Care

A key strength of palliative care is its reliance on an interdisciplinary care team, which may include physicians, advanced practice providers, nurses, social workers, chaplains, care coordinators, pharmacists, and behavioral health professionals. These team members work collaboratively to address the complex physical, emotional, social, and spiritual needs of patients and their caregivers.

Many of the most valuable activities performed by the interdisciplinary team, such as care coordination, family meetings, caregiver support, advance care planning, symptom monitoring, and communication with community providers, are not adequately reimbursed under traditional fee-for-service payment structures. A PMPM model supports the full scope of services required to effectively manage serious illness and enables providers to deploy resources based on patient needs rather than billable encounters.

Encourages Proactive and Flexible Care Delivery

Palliative care often involves frequent touchpoints that occur outside of traditional office visits, including telephonic outreach, virtual consultations, caregiver engagement, and coordination across care settings. A PMPM payment methodology allows providers to deliver care in the most appropriate and timely manner without being constrained by visit-based billing requirements. This flexibility can efficiently improve symptom management, reduce avoidable utilization, and better align care with patient goals and preferences.

Aligns Financial Incentives with Value

Fee-for-service reimbursement rewards volume, while palliative care is designed to improve outcomes through coordination, symptom management, and goal-concordant care. A PMPM methodology creates a more sustainable payment structure that supports prevention of crises, reductions in unnecessary emergency department visits and hospitalizations, and improved patient and caregiver experiences.

CMS Should Consider Alternative Measures of Effectiveness

As CMS evaluates palliative care payment models, it is important to recognize that traditional utilization and disease-specific quality measures may not fully capture the value of palliative care. Success in palliative care is often reflected in outcomes that matter most to patients and families, including:

- Symptom burden reduction
- Achievement of patient-centered goals of care
- Timely advance care planning
- Improved patient and caregiver satisfaction
- Caregiver support and reduced caregiver burden
- Enhanced quality of life
- Improved care coordination across settings
- Goal-concordant care at the end of life

CMS should explore and adopt alternative quality and outcome measures that reflect these unique dimensions of palliative care. Measuring effectiveness through patient-reported outcomes, caregiver experience, care planning completion, and quality-of-life indicators would provide a more accurate assessment of program value than reliance on traditional medical utilization metrics alone.

Trinity Health recommends CMS consider the following palliative care outcome measures:

- Total Referrals
- Number of New Patients Served
- Total Patients Served
- Average Days Until First Visit
- Average Length of Stay on Palliative Care
- Average Length of Stay on Hospice
- Total Patients Discharged
- % of patients who Expired out of Hospital
- % of patients who Expired in Hospital
- % of patients Transitioned to Hospice
- % of patients Disenrolled
- % Disenrolled as No Show
- % Disenrolled as Moved Out of Area
- % Disenrolled to Nursing Home
- % Disenrolled due to Patient's Choice
- % Disenrolled due to Extended Prognosis
- % Disenrolled due to Transitioned to Other Services
- % of patients with completed Health care proxy at Admission
- % of patients with Health Care Proxy at Discharge
- % of patients with completed MOLST or DNR form at Admission
- % of patients with completed MOLST or DNR form at Discharge

LIFESTYLE INTERVENTIONS TO SLOW PROGRESSION OF ALZHEIMER'S REQUEST FOR INFORMATION

Comprehensive, intensive lifestyle interventions to slow the progression of Alzheimer's disease and cognitive decline must address nutrition, movement, sleep, stress and emotional well-being, social connection, and consumption of risky substances like tobacco and alcohol. To ensure adequate education and behavior-change in each of these domains, interventions require a multi-disciplinary, team-based approach that include content experts in each domain.

CMS should prioritize interventions that incorporate all six pillars of lifestyle medicine: healthy nutrition, physical activity, restorative sleep, stress management, avoidance of risky substances, and social connection. A comprehensive, multidomain approach is most likely to address the complex and multifactorial risk factors associated with cognitive decline.

In addition, CMS should prioritize interventions that include nutrition education and counseling provided by RDNs. Nutrition is a key component of brain health, and RDNs are uniquely qualified to translate evidence-based nutrition science into individualized, clinically appropriate interventions that support cognitive function, chronic disease management, and healthy aging.

Conclusion

We appreciate CMS's commitment to advancing value-based care, strengthening primary care, and expanding access to preventive services and we 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