



June 5, 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-1849-P; Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes

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

Dear Administrator Oz,

Trinity Health appreciates the opportunity to comment on policies set forth in CMS-1849-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. 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.

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 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.

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.

In our detailed comments below, we urge CMS to:

- Revise the inadequate payment update and provide a fair market basket update. Specifically, we recommend CMS:
 - Use its special exceptions and adjustment authority to make a one-time retrospective adjustment of 10-15% to the market basket to account for what hospitals should have received in 2022 when accounting for inflation.
 - Establish a threshold whereby if the payment differential between what was provided and actual costs is greater than 1.5 percentage points, CMS would retroactively adjust payments for that year.
 - Rebase the market baskets more frequently and at least every three years to ensure the market basket reflects the appropriate mix of services provided to Medicare beneficiaries
- Revise the uncompensated care estimate by incorporating more current data on Medicaid disenrollment and marketplace enrollment trends, adjusting projections to reflect expected coverage declines, accounting for regional variation, and delaying or moderating the proposed reduction until more complete data is available to ensure UCC payments accurately reflect hospitals’ growing uncompensated care costs.
- Not finalize the cost allocation changes for Nursing and Allied Health Education.
- Inpatient Quality Reporting Program:
 - Do not finalize adoption of new VTE measure. Should CMS move forward as proposed, the agency should delay implementation by at least two years to allow hospitals adequate time to monitor the new measure, adapt workflows, and better understand performance implications once the measure is fully operational
 - delay mandatory requirements for the Malnutrition Care Score eCQM until there is better monitoring of the malnutrition score. In addition, CMS should require CERHT vendors to accurately implement mandatory eCQMs prior to making it mandatory for hospital reporting purposes.
- Hospital Readmissions Reduction Program:
 - Urge CMS to review the underlying structure of the HRPP.
- Total Hip/Total Knee Pro-PM:
 - To improve feasibility and data accuracy, extend the reporting deadline by one month to October 31.
 - Waive IQR program penalties as hospitals have not received CMS reports from pre-op survey data reported in 2025.
- Maintain homelessness and related housing instability as CC diagnosis to properly reflect the significant clinical and operational complexity associated with caring for patients experiencing homelessness
- CJR-X:
 - If CJR-X model becomes mandatory, CMS should limit downside risk during the first year of implementation and establish a phased-in glide path to the full 2% discount factor
 - CMS should be responsible for beneficiary notification or, at minimum, provide standard templates, language, and protocols.

- Remove the Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary THA/TKA measure from the model, since it is topped out.
- Incorporate a shared savings adjustment and regional efficiency adjustment, similar to approaches proposed for ACOs.
- Issue target prices in January preceding a performance year, rather than the proposed November.
- Define low-volume hospitals as hospitals with 50 or less episodes.

HOSPITAL FINANCIALS AND MARKET BASKET UPDATE

Given the extraordinary inflationary environment and continued labor and supply cost pressures hospitals face, Trinity Health is deeply concerned with the proposed net operating payment increase of 2.4% in the FY27 IPPS rule. This woefully inadequate update will result in the seventh consecutive year where the IPPS payment update is not reflective of the actual cost increases hospitals are experiencing. This update, as well as the payment updates for FYs 2021-2026, does not capture the unprecedented increase in the cost of caring for patients and comes at a time when many non-profit health systems are struggling to stay afloat with high inflation, and increased drug, supply, and labor expenditures.

It's notable that for FYs 2021-2023, the difference between the hospital market basket used for the update and actual increase exceeded 0.5 percentage points. For FY 2022 alone, the understatement was 3.0 percentage points. The combined understatement of the update in these three years was 4.3 percentage points as shown in the table below:

IPPS Market Basket	FY 2021	FY 2022	FY 2023
Forecast Used in the Update	2.4	2.7	4.1
Actual Based on Later Utilization	3.0	5.7	4.8
Difference	-0.6	-3.0	-0.7

The combined 4.3 percentage point understatement of the FY 2021 through FY 2023 market basket results in a permanent reduction in IPPS payments below the rate of inflation. To avoid this permanent reduction in IPPS payments below the rate of inflation, CMS should make an adjustment for forecast error consistent with the policy it has adopted under the SNF PPS.

Pursuant to section 1886(b)(3)(B)(xi)(II) of the Act, the Secretary reduces the IPPS market basket increase by the “10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as produced by the Secretary for the 10-year period ending with the applicable fiscal year).” The theory behind the offset for economy wide total productivity is that the hospital sector should be able to realize the same productivity gains as the general economy.

However, CMS itself takes issue with the assumption that hospitals can recognize the same kinds of productivity gains as the general economy. In a memorandum dated June 2, 2022, OACT stated: “over the period 1990-2019, the average growth rate of hospital TFP using the two methodologies ranges from 0.2 percent to 0.5 percent, compared to the average growth of private nonfarm business TFP of 0.8 percent.” The memorandum also indicates that an assumed future rate of hospital industry productivity growth of 0.4 percent per year remains reasonable compared to an assumed rate of productivity growth in the private nonfarm business sector of 1.0 percent.

We urge CMS to:

- **Use its special exceptions and adjustment authority to make a one-time retrospective adjustment of 10-15% to the market basket to account for what hospitals should have received in 2022 when accounting for inflation.**
- **Establish a threshold whereby if the payment differential between what was provided and actual costs is greater than 1.5 percentage points, CMS would retroactively adjust payments for that year.**
- **Rebase the market baskets more frequently and at least every three years to ensure the market basket reflects the appropriate mix of services provided to Medicare beneficiaries.**

DSH PAYMENTS

Proposed total uncompensated care payment and supplemental payment is \$7.563 billion, which is a decrease of about \$258 million (-3.3%) compared to FY 2026.

Trinity Health is concerned that the proposed 3.3% reduction to DSH uncompensated care (UCC) payments does not reflect current and emerging coverage losses that are resulting from Medicaid eligibility changes that were finalized in the One Big Beautiful Bill and the expiration of the marketplace subsidies. These policies will increase the number of uninsured individuals and exacerbate uncompensated care burdens. **We urge HHS to revise its uncompensated care estimate by incorporating more current data on Medicaid disenrollment and marketplace enrollment trends, adjusting projections to reflect expected coverage declines, accounting for regional variation, and delaying or moderating the proposed reduction until more complete data is available to ensure UCC payments accurately reflect hospitals' growing uncompensated care costs.**

NURSING AND ALLIED HEALTH EDUCATION (NAHE)

In the proposed rule, CMS addresses the Nursing and Allied Health Education pass-through costs and attempts to clarify that it should only include direct and indirect costs directly attributable to the NAHE program. CMS specifically calls out the inclusion of home office cost allocations included in the indirect costs and proposes a discrete cost allocation methodology of sub-scripting general service cost centers for the stepdown allocations.

We disagree with these proposals, in that they run counter to the long-standing cost-finding principles at 42 CFR 413.24, and we urge CMS to not finalize.

CMS and the MACs in recent years have been pushing back on the inclusion of the home office cost allocations that run through the Administrative and General cost center of a hospital cost report being allocated to the NAHE cost centers, arguing that related-party costs are not includable in the NAHE cost. And CMS specifically calls out home office costs being allocated to NAHE in the proposed rule. However, under the related-party principles, any allocation is reduced to cost, and the hospital stands in the shoes of the related-party (home office). Under 42 CFR 413.17, Medicare treats transactions between a hospital and a related organization as if the hospital is essentially dealing with itself. Therefore, allowable cost equals the cost incurred by the related organization, not what the hospital pays. In the proposed rule, CMS clarifies the 2001 Federal Register reference to "total costs", as including direct and indirect costs directly attributable to the NAHE program. But in 2001, many administrative functions that were performed at the hospital and were allocated to NAHE are now performed at the home office level due to cost constraints and efficiency, such as payroll and employee benefits (i.e. health insurance, etc.). Those costs are still directly attributable to the employees and students of the NAHE, but are allocated from the home office to the hospital.

In their discussion in the proposed rule, CMS makes reference to 66FR 3367 as support. However, that final rule is focused on related educational facilities passing along or redistributing their education costs to the provider and is the reason for certain regulatory requirements, including the requirement that the hospital collects the tuition and the hospital issues the degree to the student versus the other educational institution, not the stand-in-the-shoes type of related-party costs allocated from a Home Office.

Whereas providers that operate their own programs may receive reasonable cost reimbursement for both the classroom instruction and the clinical training costs, but no reimbursement for costs incurred by a related educational institution, providers that would qualify under section 4004(b) of Public Law 101-508 may receive reasonable cost reimbursement for the clinical training costs only, and for the clinical training costs incurred by a related educational institution. We believe that the language included in the Committee Report that accompanied Public Law 101-508 supports this distinction between total allowable costs for provider-operated and nonprovider-operated programs. In that report, the conferees noted that--
`in the case of hospital-operated nursing and allied health education programs, the Secretary does not recognize costs incurred by a related educational organization as allowable educational costs since such costs are a redistribution of costs from the educational institution to the hospital. Although [section 4004 of Public Law 101-508] provides for recognition of the costs incurred by a related educational organization for clinical training on the hospital's premises in the case of a hospital-supported program, the conferees intend that nothing in [section 4004 of Public Law 101-508] should be construed as requiring the Secretary to modify his current policy in regard to the determination of reasonable costs for a hospital operated program" (H.R. Rept. No. 964, 101st Cong., 2d Sess. 719 (1990)).

The proposed rule continues to push for discrete costing through the employment of sub-scripting general service cost centers to control the allocation of indirect costs via the Worksheet B-1 stepdown process and only allocate identifiable indirect costs to the NAHE cost center. This level of discrete costing has not been done before. **This would be an administrative burden on both the hospital and the MAC auditors and opens the door for discrete costing for other areas, which could see multiple allocations required of each general service cost center. Thus, the proposal would abandon the basis of the current cost report cost-finding process of the Worksheet B Part I stepdown methodology.**

To discretely capture NAHE indirect costs, a hospital would need: time studies for shared staff (nurse educators, supervisors); space utilization tracking by program vs. patient care; department-level allocation redesign; and parallel cost systems for education vs. operations. It would be extremely burdensome and costly with no reliable improvement in accuracy and likely less reliable due to estimation subjectivity. This also ignores the fact that the clinical training of NAHE students occurs in the clinical areas of the hospital, making such differentiation nearly impossible.

Indirect costs are inherently not directly identifiable. The cost finding process requires allocation of indirect costs via the stepdown process that has been in place consistently for decades, not direct tracing. Indirect costs are, by definition, shared overhead costs, i.e. administration, depreciation, utilities, etc. If hospitals were allowed (or required) to carve out unique indirect costs just for NAHE, it would undermine standardized RCC / stepdown methodologies, create non-comparable provider-specific allocations, and increase audit subjectivity and manipulation risk. The stepdown / allocation method preserves uniformity, discrete tracking would not.

HOSPITAL QUALITY AND PAY-FOR-PERFORMANCE PROGRAMS

Inpatient Quality Reporting (IQR) Program

New Measures

The FY27 IPPS proposed three new measures for IQR: Advance Care Planning (ACP) eQCM, Excess Days in Acute Care (EDAC) after hospitalization for Diabetes, and Hospital Harm – Postoperative Venous Thromboembolism (VTE (eQCM).

Trinity Health does not support the adoption of a new VTE eQCM alongside the removal of VTE-1 and VTE-2. The existing VTE measures are high-performing, well-established, and supported by standardized clinical workflows, making them both reliable and feasible for hospitals to implement. While we support CMS’s goal of advancing measure development and improving the program, the proposal would reduce the number of available self-selected measures without introducing sufficient new options, thereby increasing the difficulty for hospitals to meet IQR program requirements. **If CMS finalizes this proposal, we strongly urge the agency to delay implementation by at least two years to allow hospitals adequate time to monitor the new measure, adapt workflows, and better understand performance implications once the measure is fully operational.**

eQCM Reporting

The rule proposes to shift the Malnutrition Care Score eQCM from the self-select option to mandatory beginning with the 2028 reporting period/FY 2030 payment determination in alignment with CMS strategy to transition to fully digital quality measurement. In addition, the Hospital Harm—Falls with Injury eQCM and the Hospital Harm—Postoperative Respiratory Failure eQCM would become mandatory reporting after two years of self-selected reporting.

The Malnutrition Care Score eQCM is a challenging measure in that the measure contains multiple “if” statements and it is difficult for hospitals to track their progress; we have concern with making the measure mandatory with the 2028 reporting period. In addition, not all CERHT vendors are able to accurately capture the required data elements for the Malnutrition Care Score eQCM. **Trinity Health recommends that CMS delay mandatory requirements for this measure until there is better monitoring of the malnutrition score. In addition, CMS should require CERHT vendors to accurately implement mandatory eQCMs prior to making it mandatory for hospital reporting purposes.**

More broadly, we urge CMS to provide greater transparency regarding how the agency intends to use eQCM data moving forward. Trinity Health—and we expect other hospitals—continues to experience significant challenges with vendor timelines, as measure updates are often not available until four to seven months into the calendar year, followed by subsequent corrections and re-releases. These delays raise concern about how CMS will account for incomplete or potentially inaccurate data submissions during this period. In addition, the transition to FHIR-based reporting introduces a risk of duplicate submissions for the same encounter, in contrast to the current QRDA-I process, which allows hospitals to validate and submit finalized data once. **To address these issues, Trinity Health recommends that CMS establish a pilot program with health systems to test**

and refine these processes, and we would welcome the opportunity to partner with CMS in designing and participating in such a pilot.

Hospital Readmissions Reduction Program (HRRP)

Trinity Health has significant concerns with the underlying structure of the HRRP and we urge CMS to re-evaluate the program. Because there is no target for readmissions (i.e., how low is appropriate), hospitals will continue to be penalized even if national healthcare achieves a rate that represents excellence in care simply because not all readmissions are avoidable.

In reviewing several years of CMS data on hospital-wide readmissions, there has been a decrease in readmission rates. However, the readmission penalties under the HRRP continue to increase since the program is structured to penalize as many hospitals as possible without consideration for avoidable readmissions or reaching an acceptable level of readmissions. With the proposed sepsis addition, CMS notes in the proposed rule that 86% of hospitals will be penalized by the HRRP. Even if all hospitals improve across all populations (measures become topped out), there will still be significant penalties.

When reviewing the structure of the program, CMS should consider the following:

- Exclusion of readmissions unrelated to the initial admission in determining HRRP penalties.
- CMS should not hold hospitals accountable for unplanned, unrelated admissions because they are unpredictable and not typically preventable. However, these readmissions are currently included in the HRRP penalty calculation, even though they are not associated with care delivered by the hospital.
- MedPAC has raised concerns about the penalty formula's "multiplier effect" that results in (1) readmissions penalties that far exceed the cost of excess readmissions, and (2) an inverse relationship between national readmissions rates and hospital penalties.
- There are limitations with the statutory requirement defining how CMS must measure excess readmissions because rates for hospitals with less volume are more heavily weighted toward the national average.
- Comparison against national averages may inflate the number of penalized hospitals. Although readmission rates have declined nationally, over 80 percent of hospitals are incurring a penalty during each year of the HRRP
- MedPAC recommended to Congress an alternative method for assessing hospital performance that respects the intent of the program while recognizing improvements. The proposal would set a risk-adjusted readmission rate target based on historical national performance and a hospital's share of low-income beneficiaries. Such a target would create a defined benchmark for hospitals to work toward during the performance year and, unlike the current system, every hospital could avoid a penalty by achieving fewer readmissions than the target. Ultimately, the program would continue to reduce expenditures related to readmissions, in addition to any penalties imposed on hospitals that fail to reduce readmissions below the predetermined target.

Total Hip/Total Knee Pro-PM

Trinity Health urges CMS to reevaluate and refine the TH/TK PRO-PM to ensure more feasible implementation for hospitals. The current timelines present significant operational challenges, as the survey period closes on August 31 with a reporting deadline of September 30—leaving limited time for data collection, validation, and submission. These requirements are compounded by concurrent reporting obligations, including pre-operative surveys and hybrid measures. **To improve feasibility and data accuracy, we recommend extending the reporting deadline by one month, to October 31.**

In addition, for post-op survey reporting due in 2026, hospitals have not received CMS reports from pre-op survey data reported in 2025. Without access to these reports, hospitals lack critical insight into the applicable patient population, performance benchmarks, and whether required thresholds have been met. **Given these delays, Trinity Health strongly urges CMS to waive any IQR program penalties by making the measure voluntary reporting for 2026 to ensure hospitals are not held accountable for performance metrics they have not had a fair opportunity to evaluate or improve.**

MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP UPDATES

CMS proposes several MS-DRG changes, including the creation of new extensive and complex spinal fusion MS-DRGs, reorganization of cardiac pacemaker revision and device replacement MS-DRGs, and deleting a number of MS-DRGs with severity levels to create a few single-base MS-DRGs.

Trinity Health has significant concerns with the proposal to remove homelessness and related housing instability from CC to NonCC as this change fails to recognize the significant clinical and operational complexity associated with caring for patients experiencing homelessness. Removing this designation would undermine the Administration's goals under the Make America Healthy Again initiative by disregarding the profound impact that social drivers of health have on patient outcomes and costs. Patients experiencing homelessness often require more intensive care coordination, as safe and appropriate discharge planning is substantially more complex, particularly for those with conditions requiring oxygen, refrigerated medications, or ongoing treatment adherence that cannot be readily supported without stable housing. This population necessitates additional hospital resources, including extended length of stay, coordination with community-based organizations, and increased case management and social work involvement. **The cost of care for these patients is demonstrably higher and CMS should maintain homelessness and housing instability as a CC to appropriately reflect patient complexity and support effective care delivery.**

PAYMENT MODELS

Comprehensive Care for Joint Replacement Expanded (CJR-X)

Beginning October 1, CMS proposes to expand the Comprehensive Joint Replacement Model to require mandatory participation for all acute care hospitals except those participating in the Transforming Episode Accountability Model (TEAM) and those located in Maryland.

The model would:

- Hold hospital participants responsible for the quality and costs of Medicare Parts A and B items and services furnished during a lower extremity joint replacement (LEJR) episode of care, from the date of inpatient admission or outpatient procedure through 90 days post-discharge.
- Use performance on five inpatient and outpatient quality measures to inform a weighted composite quality score, which would in turn affect reconciled payments.
- Retrospectively reconcile Medicare fee-for-service (FFS) payments during the episode against a target price.
- Include a discount factor of up to 2% as Medicare's share of episode savings.
- Exclude low-volume hospitals on a year-by-year basis.
- Apply stop-loss and stop-gain limits, including lower limits for rural, Medicare dependent, sole community and safety-net hospitals.
- Allow for financial arrangements with collaborators and beneficiary incentives.
- Waive certain Medicare program requirements.
- Share beneficiary-identifiable and aggregate data with participants.

Trinity Health is a leading health system in value-based care and we strongly believe that innovative payment and delivery models are essential to addressing rising healthcare costs nationwide. **However, we do not support making the CJR-X model mandatory, particularly given the ongoing shift of joint replacement procedures to ambulatory surgical centers (ASCs).** As more routine cases migrate to outpatient settings, hospitals are increasingly left caring for patients with greater medical and social complexity, which can significantly affect performance under a mandatory bundled payment model. In addition, TEAM just started in January 2026 and CMS has not afforded TEAM the ability to illustrate results prior to mandating CJR-X.

A mandatory bundled payment model would be significantly burdensome on hospitals as evidenced from previous models that required significant resources and operational capabilities. If CMS moves forward with making the CJR-X model mandatory, we strongly urge the agency to create a glidepath to risk and limit downside risk during the first year of implementation to allow hospitals adequate time to prepare and operationalize the model. In addition, establishing a phased-in glide path to the full 2% discount factor would be particularly important for hospitals with limited experience in value-based care, enabling them to build the necessary infrastructure, align clinical workflows, and mitigate financial risk during the transition period.

Beneficiary Notification

CMS proposes that participating hospitals must provide written notification to each CJR-X beneficiary of their inclusion in the model; this would need to occur prior to discharge from the anchor hospitalization or procedure.

The notification process is too burdensome and onerous for hospitals to carry out. Since CJR-X is being proposed as a mandatory model, this communication should come from CMS. If hospitals are required to own this communication, CMS should provide, at a minimum, standard templates, language and protocols related to beneficiary notification.

Quality Measures

CMS proposes assessing performance on five quality measures in the CJR-X model: Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary THA/TKA; Hospital Visits within 7 Days of Hospital Outpatient Department Surgery (HOPD); Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey; Outpatient and Ambulatory Surgery (OAS) CAHPS; and Hospital-Level THA/TKA Patient Reported Outcome-Based Performance Measure.

Trinity Health generally supports including the proposed measures in CJR-X; however, the Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary THA/TKA measure is topped out and should not be included in the mandatory model. If a measure is topped out, the methodology forces “losers” even though overall performance is high.

Risk Adjustment and Normalization

For CJR-X, CMS proposes to use the same risk adjustment methodology and variables that are used in TEAM. Specifically, the agency proposes to risk-adjust target prices at the hospital level using hospital bed size and safety net risk adjustment factors.

Since this is proposed as mandatory model, Trinity Health is concerned that the methodology would unintentionally disadvantage hospitals that have already achieved significant efficiencies in managing bundled services. As designed, the model risks creating a dynamic in which early success ultimately results in financial penalties, similar to challenges observed in other value-based care programs. Over time, hospitals may reach a

performance ceiling where further improvements are limited, yet they remain subject to downside risk without a meaningful opportunity to exit the model once high efficiency levels are achieved.

To address this concern, we urge CMS to incorporate a shared savings adjustment, similar to approaches proposed for ACOs, that recognizes and rewards hospitals with a sustained track record of efficiency. CMS should also consider implementing a regional efficiency adjustment, comparable to ACO models, to account for geographic variation and ensure that already high-performing providers are not disadvantaged relative to their peers. For example, CMS could adjust benchmarks or provide targeted payment enhancements to ensure that high-performing participants can continue to achieve savings and remain engaged in the program. Such an approach would better align incentives, promote long-term participation, and avoid penalizing hospitals that have been proactive in advancing value-based care.

Target prices

CMS would provide preliminary target prices to CJR-X participants for each episode type and region based on 100% regional data for all CJR-X participants.

CMS proposes to release target prices by the end of November preceding each performance year; however, Trinity Health recommends that CMS instead issue these prices in January. This adjustment would better align with hospital operational realities, as the fall season is already heavily constrained by competing priorities, including year-end reporting requirements and other regulatory deadlines.

Low-Volume Hospitals

Hospitals would not trigger CJR-X episodes for a performance year if they are low-volume, defined as those hospitals with fewer than 31 LEJR episodes performed during the applicable three-year baseline period.

Thirty-one episodes over the baseline period—averaging roughly 10 episodes per year—does not provide sufficient volume for participants to meaningfully engage in or derive value from the model. Such low volume introduces significant variability in performance outcomes and makes it difficult to generate stakeholder buy-in or justify the operational changes needed to succeed. **To address these concerns and support more effective participation, Trinity Health urges CMS to increase the low-volume threshold from 31 to 50 episodes.**

TRANSFORMING EPISODE ACCOUNTABILITY MODEL (TEAM)

The FY27 rule proposes several changes to TEAM, including:

- Adding new Medicare Severity Diagnosis Related Groups (MS-DRGs) to the spinal fusion episode category.
- Adjusting episode attribution.
- Adjusting the measurement performance periods for certain quality measures.
- Adjusting the construction of the CQS baseline period.
- Capturing Ambulatory Payment Classification (APC) and MS-DRG changes in preliminary target prices.
- Adjusting the construction of the prospective normalization factor

Trinity Health supports the proposed updates to the TEAM model. **CMS also seeks input on whether participation should be extended to ambulatory surgical centers (ASCs); however, we do not believe including ASCs would be appropriate.** ASCs operate under a fundamentally different payment structure with lower reimbursement reflecting their cost base, and they typically lack the infrastructure and staffing necessary to manage the full continuum of care required under a bundled payment model. Additionally, care coordination in

the ASC setting is often limited, and patients who experience complications following an ASC procedure are more likely to seek care at a hospital rather than return to the ASC. This dynamic creates significant challenges in establishing accountability and determining which provider is responsible for the episode of care within the model. For these reasons, we recommend that CMS not extend TEAM participation to ASCs.

CONCLUSION

We appreciate CMS' ongoing efforts to improve payment systems across the delivery system. We welcome the opportunity to inform any future Medicare and 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