May 27, 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-1845-P; Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2027 and Updates to the IRF Quality Reporting Program

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

Dear Administrator Oz,

Trinity Health appreciates the opportunity to comment on policies set forth in CMS-1845-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 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:

- Not require that initial weekly interdisciplinary team meeting occur withing four days of admission. If CMS decides to move forward, we recommend the agency consider alternatives that allow for operational flexibility while maintaining a strong emphasis on interdisciplinary decision-making
- To preserve access to IRFs, do not align IRF payment methodology with the SNF payment methodology.

Timing of Initial Interdisciplinary Team Meeting

CMS is proposing to amend its regulations to require that the initial weekly interdisciplinary team meeting occur within four days of admission and proposes subsequent team meetings must occur within seven days of the last meeting.

We value CMS's emphasis on interdisciplinary collaboration as a foundational element of effective inpatient rehabilitation and we strongly support timely, coordinated care planning that reflects the needs and goals of each patient. However, while well-intentioned, we have concerns that the proposal to require a formal IDT meeting within four days of admission may introduce significant operational challenges.

Coordinating full participation of the interdisciplinary team—including physicians, rehabilitation nursing, multiple therapy disciplines, and case management—within a four-day window may not always be feasible particularly in community-based settings. Current staffing models, including therapy and nursing ratios, are intentionally designed to support safe, high-quality care delivery across the full patient population and may not allow for rapid convening of a full interdisciplinary team within four days for every admission without disrupting patient care workflows. These challenges are further compounded by weekend and late-day admissions. Patients admitted on Fridays or weekends often experience limited access to the full complement of interdisciplinary team members, which can delay the completion of comprehensive evaluations necessary for meaningful participation in the IDT process. Requiring a formal IDT meeting within four days under these conditions risks forcing care planning discussions to occur before sufficient clinical information is available, potentially resulting in incomplete or less clinically informed plans of care. Such outcomes would undermine the intent of the requirement and may detract from, rather than enhance, patient-centered rehabilitation planning.

We also note that IRFs already engage in ongoing interdisciplinary collaboration early in the patient stay through physician oversight, therapy evaluations, nursing assessments, and care coordination activities. We encourage CMS to recognize these existing practices and to consider whether a more flexible approach would better support high-quality care.

For the reasons noted above, we urge CMS to not finalize this proposal. **If CMS decides to move forward, we recommend the agency consider alternatives that allow for operational flexibility while maintaining a strong emphasis on interdisciplinary decision-making. Such alternatives could include permitting the initial formal IDT meeting to occur within a broader initial timeframe, recognizing interdisciplinary collaboration through documentation rather than a single meeting requirement, or allowing reasonable accommodations for weekend and late-day admissions. These approaches would better align with workforce realities, clinical judgment, and efficient care delivery.**

Request for Information: Future IRF Payment Reform

CMS suggests that the current classification system does not properly account for true patient acuity and is seeking feedback on modifying the IRF PPS in a way that mirrors the approach used under SNF PPS.

Specifically, CMS has developed 15 IRF clinical categories to potentially replace the use of impairment group codes and rehabilitation impairment categories. In addition, CMS has developed comorbidity score bins that would tier patients under an updated payment system.

Trinity Health has significant concerns regarding the proposal to further align IRF payment methodology with the SNF payment framework, particularly as it relates to access to care and the long-term sustainability of IRFs.

IRFs provide a distinct level of care characterized by intensive therapy requirements, close physician involvement, and coordinated interdisciplinary services for patients with complex medical and functional needs. These services differ in both scope and intensity from those typically provided in SNFs. Payment alignment that does not fully account for these differences risks undervaluing IRF care and may create financial pressures that limit providers' ability to serve patients who are most likely to benefit from inpatient rehabilitation.

From an access-to-care perspective, inadequate payment could result in reduced IRF capacity, particularly for patients with higher acuity, complex diagnoses, or social risk factors. This is of particular concern for rural communities and underserved populations, where IRFs may already operate with narrow financial margins and limited alternatives for specialized rehabilitation care. Limiting access to IRF services could have downstream consequences, including longer acute care stays, increased readmissions, and diminished functional outcomes.

We are especially concerned about the impact of payment policy changes on mission-driven providers that serve a disproportionate share of Medicare, Medicaid, and low-income patients. Stable and appropriate payment is critical to sustaining investments in specialized staff, interdisciplinary care models, and transition-of-care supports that promote recovery and independence.

We urge CMS to proceed cautiously with any payment methodology alignment and to ensure that IRF reimbursement continues to reflect the unique clinical role and resource requirements of inpatient rehabilitation. We encourage CMS to carefully assess the potential impact on access, quality, and provider sustainability and to engage stakeholders before finalizing changes with significant implications for patients and communities.

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