Trinity Health

July 29, 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: Medicaid Program; Community Engagement Requirement for Certain Individuals

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

Dear Administrator Oz,

Trinity Health appreciates the opportunity to comment on policies set forth in CMS-2454-IFC. 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.

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.

Medicaid plays a critical role in our ability to care for the communities we serve with 17% of our patients being covered by the program. The program serves a vulnerable population, and we urge the Centers for Medicare and Medicaid Services (CMS) to make revisions to the interim final rule (IFR) so that eligible individuals do not lose necessary coverage due to administrative barriers.

In our detailed comments below, we urge CMS to:

- Remove the medical frailty requirement that an individual's condition has to limit their ability to meet community engagement requirements.

- Work with states to implement a simple, streamline approach for determining an individual's condition limits their ability to meet community engagement requirements (e.g. checking a box in the electronic health record) if the rule is finalized as drafted.
- Require that a provider's determination of medical frailty be done only once every 12 months. If required more frequently (every three or six months), the determination should be done without needing to schedule a doctor's visit.
- Allow provider determinations for medical frailty be done via telehealth.
- Require states to reimburse any provider visits necessary to meet the community engagement requirement.
- Require that states implement a simple signature process for hospital presumptive eligibility (HPE), similar to the existing process.
- Require that states ensure their state-specific requirements and policies are clear and are included in totality on the Medicaid application so that individuals fully understand what they are attesting to during the HPE process.

Medical Frailty

Statute requires CMS to exempt medically frail individuals from the community engagement requirements. In the IFR, CMS defines medical frailty based on whether an individual has a particular diagnosis or condition AND whether that diagnosis or condition impairs an individual's ability to engage in community engagement activities.

States must first attempt to verify medical frailty using existing information, such as claims or encounter data. Through Dec. 31, 2027, states may accept self-attestation for medical frailty and beginning Jan. 1, 2028, states may allow self-attestation only once during an individual's continuous period of enrollment. After a self-attestation has been used, states must require documentation to confirm the individual's current medical frailty status at the individual's next scheduled renewal and must reverify that an individual is medically frail at least every 12 months, or more frequently at a state's discretion.

While the statute authorizes the Secretary to define medical frailty, the IFR adopts a relatively narrow framework that requires not only the presence of a qualifying condition but also a determination that the condition significantly limits an individual's ability to meet community engagement requirements. Trinity Health believes this two-part test extends beyond statute and does not reflect Congressional intent. If finalized, this policy could lead to the loss of health care coverage for individuals with chronic or complex conditions who face real challenges in maintaining consistent participation.

CMS guidance suggests that common chronic conditions such as a cancer diagnosis or congestive heart failure generally would not qualify absent significant functional impairment. This interpretation does not fully capture the day-to-day realities of managing chronic illness. There are certain conditions that fluctuate or worsen episodically, affecting an individual's ability to maintain employment or participate in structured activities. Under the IFR, some of these individuals may be at risk of losing coverage despite ongoing medical needs, which could contribute to interruptions in care and poorer health outcomes.

The narrower requirement would also create unexpected barriers for both individuals and providers. If states choose to require a provider visit every 3-6 months to confirm an individual's condition limits them from being able to meet community engagement requirements, individuals may be challenged getting an appointment with their primary care provider—especially in light of the Nation's primary care provider shortage. In addition, the IFR does not include guidance for state implementation and, as such, there may be completely different provider certification processes in each state. For a multistate health system that has implemented the single largest instance of EPIC, Trinity Health's EHR, we would experience increased costs of modifying our EHR system to meet each state requirement, further increasing burden.

To address these concerns, Trinity Health urges CMS to:

- **Remove the medical frailty requirement that an individual's condition has to limit their ability to meet community engagement requirements.**

- **Work with states to implement a simple, streamline approach for determining an individual's condition limits their ability to meet community engagement requirements (e.g. checking a box in the electronic health record) if the rule is finalized as drafted.**
- **Require that a provider's determination of medical frailty be done only once every 12 months. If required more frequently (every three or six months), the determination should be done without needing to schedule a doctor's visit.**
- **Allow provider determinations for medical frailty be done via telehealth.**
- **Require states to reimburse any provider visits necessary to meet the community engagement requirement.**

Hospital Presumptive Eligibility (HPE)

The IFR directs hospitals to determine whether individuals are subject to the community engagement requirements and to obtain attestations of prior compliance for one or more months preceding application, as specified by the State. This approach introduces additional screening responsibilities in time-sensitive clinical settings, where the primary focus must remain on ensuring timely access to care.

Assessing compliance requires interpretation of nuanced eligibility categories, including distinctions between "specified excluded individuals" and "mandatory exceptions," as well as evaluation of prior activities across multiple domains such as employment, education, and community service. These tasks extend beyond the traditional scope of HPE and may introduce additional compliance risk. Over time, this could discourage hospital participation in HPE programs, potentially limiting an important pathway for individuals to obtain immediate coverage and access needed services.

To ensure that the community engagement attestation requirement does not add unnecessary burden for individuals and hospitals, we urge CMS to require that states implement a simple signature process for HPE, similar to the existing hospital presumptive eligibility process. The final rule should also require states to ensure that their state-specific requirements and policies are clear for individuals and are included in totality on the Medicaid application so that individuals fully understand what they are attesting to.

Conclusion

We urge CMS to implement community engagement requirements in a manner that ensures eligible individuals are able to navigate the new requirements and maintain coverage and care. 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