



October 19, 2026

The Honorable Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

RE: QSO-26-15-CAH: Evaluation of Compliance with Critical Access Hospital Rural and Distance Requirements

Dear Administrator Oz:

On behalf of the National Rural Health Association (NRHA), thank you for issuing updated guidance regarding the evaluation of critical access hospital (CAH) compliance with rural and distance requirements through Quality, Safety & Oversight Memorandum QSO-26-15-CAH, which replaces the prior guidance contained in SC-16-08-CAH. We appreciate CMS' continued commitment to the needs of the more than 60 million Americans that reside in rural areas, and we look forward to our continued collaboration to improve health care access throughout rural America.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, clinics, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

The CAH program exists because Congress recognized that many rural communities cannot sustain access to hospital services under traditional reimbursement methodologies. NRHA appreciates CMS's efforts to provide greater clarity and consistency regarding the process used to evaluate ongoing CAH eligibility. While NRHA understands CMS's responsibility to ensure facilities continue to meet statutory requirements, we are concerned that changes in how distance and eligibility determinations are evaluated could inadvertently create instability for existing rural providers that have long served as the backbone of their communities. We respectfully request additional clarification and flexibility from CMS regarding implementation of the following elements.

Support for Predictable, Periodic Reviews

NRHA appreciates CMS's efforts to establish greater predictability in eligibility reviews. The revised framework appears to decouple rural and distance eligibility reviews from routine recertification surveys, while permitting reviews when specified events occur and establishing decennial reviews beginning in calendar year 2033. NRHA applauds CMS for taking steps to reduce recurring administrative burden for small rural CAHs.

Necessary Provider Documentation Concerns

NRHA continues to have concerns with CMS's requirement that facilities are responsible for producing documentation demonstrating that a Necessary Provider (NP) designation was issued by the state before January 1, 2006. CMS approved state plans implementing the NP provisions and certified the corresponding facilities. Therefore, we believe CMS should recognize a presumption that hospitals certified prior to January 1, 2006, under CAH eligibility standards have satisfied the NP requirement unless compelling evidence demonstrates otherwise. Placing the full burden of proof on facilities for decisions made by states

and approved by CMS more than twenty years ago creates an unreasonable administrative challenge and risks destabilizing hospitals that have relied on those determinations in good faith.

At a minimum, CMS should:

- Accept a broad range of historical documentation as evidence of NP status.
- Establish a good-faith evidentiary standard when official state records are unavailable.
- Permit state attestations when original records can no longer be located.
- Avoid penalizing hospitals for the absence of records that were never expected to be retained for decades after certification.

Clarification Regarding Distance Review Methodology

Effective September 20, 2026, CMS will conduct an immediate distance-eligibility review when a new acute care hospital opens nearby. This trigger-based approach means that the entry of a new hospital into a market may place an existing CAH's designation under review even when the CAH itself has not changed its operations, location, or services. NRHA is concerned that methodological changes, if interpreted too rigidly, could place rural communities in a difficult position. Efforts to expand access in a rural community should not unintentionally jeopardize existing CAHs that continue to serve as the primary source of emergency and inpatient care in a region.

NRHA encourages CMS to clearly articulate:

- How existing CAHs will be treated when new hospitals, provider-based locations, or service expansions alter local health care geography.
- Whether and how CMS will consider actual community reliance, travel patterns, geography, and service availability when evaluating compliance.
- The processes available to affected hospitals before adverse eligibility determinations are made.

The CAH program has been essential to preserving access to emergency, inpatient, and outpatient services in rural America. As CMS implements this updated guidance, we encourage the agency to prioritize continuity of care, administrative feasibility, and preservation of the existing rural safety net while maintaining program integrity. Thank you for your consideration of these comments. We look forward to continuing to work with CMS to ensure rural communities maintain access to the care they need. To discuss further or for additional information, please contact NRHA's Chief Policy Officer, Carrie Cochran-McClain, at ccochran@ruralhealth.us.

Sincerely,



Alan Morgan
Chief Executive Officer
National Rural Health Association

CC: Karen Tritz, Director, Survey & Operations Group, CMS Center for Clinical Standards and Quality