National Rural Health Association

August 31, 2026

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

**RE: CMS-1850-P;** Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; and Quality Reporting Programs; Including the Hospital Outpatient Quality Reporting Program and Ambulatory Surgical Center Quality Reporting Program; Request for Information on Strengthening the Standardization and Comparability of Hospital Price Transparency (HPT) Data

***Submitted electronically via regulations.gov.***

Dear Administrator Oz,

The National Rural Health Association (NRHA) is pleased to offer comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule for the Medicare Hospital Outpatient Prospective Payment System (OPPS) for calendar year (CY) 2027. We appreciate CMS' continued efforts to update payment systems and improve quality and transparency, while recognizing the unique challenges faced by rural hospitals and beneficiaries. NRHA is committed to working with CMS to ensure that the needs of the more than 60 million Americans that reside in rural areas are supported by regulatory changes that strengthen, rather than erode, the rural health safety net. 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, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

## II. Proposed Updates Affecting OPPS Payments.

### *B. Proposed Conversion Factor Update.*

CMS proposes a 2.4% outpatient department payment increase for CY 2027, based on a projected 3.2% hospital market basket increase, reduced by a 0.8% productivity adjustment. Total payments for hospital outpatient services are projected to reach $100.9 billion, an increase of approximately $9.5 billion over CY 2026.

After accounting for all proposed policies, CMS estimates rural hospitals will see an average 6.4% increase in CY 2027 payments, compared to 1.9% for urban hospitals. NRHA recognizes CMS for the payment update, but we are concerned that this figure obscures the 340B remedy recoupment offset discussed in Section V below, and that the increase will not be felt equally across rural hospitals, particularly those participating in the 340B program.

RuralHealth.US
50 F. St., N.W., Suite 520
Washington, DC 20001 | 202-639-0550

### *C. Proposed Wage Index Changes.*

CMS proposes to adopt the FY 2027 IPPS post-reclassification wage index for OPPS, which CMS estimates will result in no change for urban hospitals and a 0.5% increase for rural hospitals. **NRHA supports this proposal** as a small but meaningful step toward reducing the urban-rural wage index gap, and we ask CMS to finalize this policy as proposed.

NRHA remains concerned about Medicare rate underpayment due to persistent labor and workforce shortages faced by rural hospitals and health systems. **It is critical that CMS explore additional refinements to the wage index methodology that would further narrow persistent rural-urban disparities in labor cost adjustments.** Since 2010, 207 rural hospitals have closed or converted to an operating model that no longer provides inpatient care.[1] Further, more than 40% of rural hospitals are now operating in the red and 417 facilities are vulnerable to closure.[2] Closures are only one measure of hospital financial instability. MedPAC's March 2026 Report to Congress shows rural hospital all-payer margins range from -2.5% to 1.3% between 2022 and 2024.[3] When hospitals operate with such narrow or negative margins, they often cut less profitable but essential service lines, most notably obstetrics or chemotherapy, leaving rural beneficiaries without a local point of access to care.[4]

### *E. Adjustment for Rural Sole Community Hospitals.*

**NRHA supports CMS' proposed continuation of the 7.1% payment adjustment for rural sole community hospitals (SCHs)**. We ask that CMS consider extending this payment increase to Medicare Dependent Hospitals (MDHs), which by definition are a similar category of rural hospital. MDHs face many of the same challenges providing care to rural patients as SCHs, including low patient volumes, a sicker patient mix, and high reliance on public payers. **CMS has the authority to make this change without legislation through a study of costs incurred by rural hospitals compared to urban hospitals.** Since 2010, 29 MDHs have closed their doors.[5] The Government Accountability Office (GAO) found that Medicare and total hospital profit margins declined for MDHs from fiscal year 2011 through 2017, from -6.9% to -12.9% and 1.6% to -0.2%, respectively.[6] This timeline shows a steeper decline than experienced by rural hospitals or all hospitals generally over the same period. NRHA contends that MDHs and low volume hospitals (LVHs) need the same financial support through OPPS payment adjustments as SCHs.

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[1] Rural Hospital Closures, N.C. Rural Health Research Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.

[2] Michael Topchik, et al., *2026 rural health state of the state*, Chartis Center for Rural Health (2026), https://www.chartis.com/insights/2026-rural-health-state-state.

[3] Medicare Payment Advisory Commission, March 2026 Report to the Congress: Medicare Payment Policy, ch. 3, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch3_MedPAC_Report_To_Congress_SEC.pdf.

[4] Michael Topchik, et al., *2026 rural health state of the state*, Chartis Center for Rural Health (2026), https://www.chartis.com/insights/2026-rural-health-state-state.

[5] Rural Hospital Closures, N.C. Rural Health Research Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill https://www.shepscenter.unc.edu/programsprojects/rural-health/rural-hospital-closures/; Rural Emergency Hospitals, N.C. Rural Health Research Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-emergency-hospitals/; (this number includes hospitals that converted to another hospital type, such as the Rural Emergency Hospital designation).

[6] Government Accountability Office, Information on Medicare-Dependent Hospitals (Feb. 2020), 21, https://www.gao.gov/assets/gao-20-300.pdf.

## V. OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals.

### *B.2.a. Proposed Payment for Specified Covered Outpatient Drugs and Other Separately Payable Drugs and Biologicals.*

CMS proposes reducing Medicare payment for most drugs acquired under the 340B program from ASP + 6% to ASP - 33.4%, based on the Outpatient Drug Acquisition Cost Survey (ODACS) CMS conducted from January through April 2026. This is a deeper cut than the ASP-minus-22.5% policy the Supreme Court struck down in 2022, citing CMS' lack of conducting the acquisition-cost survey required by statute prior to implementing the policy change. Most, but not all, of the resulting "savings" from the cuts would be redistributed across all hospitals as an 8.44% increase in payments for all other, non-drug items and services.

NRHA is pleased to see rural SCHs are exempt from the proposed -33.4 % payment reduction. As previously noted, rural hospitals experience very narrow, if not negative, margins nationally. While overall it is anticipated that rural PPS hospitals experience an increase due to the proposed 340B adjustment, there is a category of rural facilities that may see significant decreases. Specially, rural, non-SCH, 340B-participating hospitals are at potential risk. **If CMS decides to reduce outpatient drug reimbursement in CY 2027, NRHA urges the agency to exempt all rural hospitals, including SCHs, MDHs, LVHs, and rural emergency hospitals (REHs) from the policy.** In the proposed rule, CMS states that SCHs were exempted from the 340B payment adjustment primarily because these hospitals are in a more vulnerable financial position and already receive a special payment adjustment under OPPS. Given that reasoning, **NRHA proposes CMS extend the exemption to the aforementioned rural hospital designations as well.**

NRHA has concerns with the methodology CMS used to arrive at the proposed ASP-minus-33.4% rate. We urge CMS to address the following before finalizing any 340B payment reduction.

***Survey response rate and representativeness.*** Only 43.6% of survey-eligible hospitals submitted a response to the ODACS, and even within CMS' refined study population, only 41.4% of hospitals responded with usable data. Further, just 29.8% of the original eligible population reported usable acquisition-cost data. NRHA is concerned that such a consequential payment policy change be based on survey data with a response rate this low.

NRHA also questions the validity of the respondent pool. Survey response was materially lower among 340B hospitals than among non-340B hospitals throughout CMS' own analysis. For example, only 23.1% of 340B hospitals in the original population responded and reported usable data, compared to 34.9% of non-340B hospitals, and the gap persisted in the refined population of 28.6% versus 53.3%. **NRHA asks CMS to disclose how many rural and 340B hospitals specifically are represented in the final respondent pool used to set the ASP-minus-33.4% rate**, and to explain how the inverse probability weighting methodology accounts for the documented differences between respondents and the broader survey-eligible population, before relying on this rate to set payment policy.

***Outlier and exclusion methodology.*** NRHA asks CMS to provide additional transparency and rationale for the ODACS outlier methodology, including its proposal to exclude survey records with per-unit acquisition costs more than three standard deviations from the geometric mean for the applicable national drug code. We also ask the agency to clarify how this and the other data-refinement exclusions applied throughout the survey process affect the representativeness of the final rate for rural hospitals.

***Alternative ASP minus 28% methodology.*** CMS separately modeled an alternative payment rate of approximately ASP minus 28%, derived from HRSA 340B ceiling price data rather than the acquisition cost survey, which CMS estimates would reduce OPPS payment for 340B drugs by roughly $4.68 billion in CY 2027 rather than $4.85 billion under the survey-based approach. NRHA asks CMS to more fully evaluate this alternative, which relies on data already collected by HRSA and therefore would avoid many of the response-rate and representativeness concerns described above. If CMS pursues an alternative methodology along these lines, **NRHA supports weighting it using Medicare claims volume for the applicable calendar year,** and cautions against relying on a single, uniform aggregate discount factor applied across all 340B-acquired drugs rather than acquisition-cost-based rates that better reflect actual drug-specific costs.

***Extension of the 340B Payment Reduction to Non-Excepted Off-Campus Provider-Based Departments.*** CMS intends to again extend the ASP-minus-33.4% payment reduction to 340B-acquired drugs administered at non-excepted off-campus hospital outpatient departments, using the same separate legal authority CMS relied on in 2019 to close a similar gap after the initial 340B payment cut applied only to drugs paid under OPPS. Unlike the OPPS-wide component of this policy, savings from this non-excepted off-campus component are not redistributed back to hospitals through the conversion factor, they revert to the U.S. Treasury. **NRHA is concerned that this distinct, non-budget-neutral cut falls hardest on rural health systems with non-excepted off-campus provider-based departments, a category that has grown as rural hospitals and systems have consolidated and acquired physician practices in recent years.** We ask CMS to reconsider this extension or, at minimum, to redistribute any resulting savings back to affected hospitals rather than to the Treasury, consistent with the treatment of 340B savings elsewhere in this proposed rule.

### *B.6. CY 2027 Prospective Adjustment to Payments for Non-Drug Items and Services To Offset the Increased Payments for Non-Drug Items and Services Made in CY 2018 Through CY 2022 as a Result of the 340B Payment Policy.*

CMS proposes to accelerate the recoupment of the $7.8 billion in payments redistributed under the 340B payment cut the Supreme Court invalidated in 2022. Instead of the originally finalized 0.5% annual reduction over 16 years, or the 2.0% annual reduction CMS proposed and did not finalize last year. CMS now proposes a 3.0% annual reduction, compressing recovery of the full amount into roughly six years through CY 2029. This reduction applies to non-drug item and service payments broadly at affected hospitals, not just 340B participants.

**NRHA asks CMS not to finalize this change and instead retain the originally finalized 16-year recoupment schedule at 0.5% annually. Should CMS decide to move forward with a higher rate of recoupment**, **NRHA requests that CMS use, at most, the previously proposed 2.0% annual reduction rather than 3.0%.** Rural hospitals cannot sustain additional reductions layered on top of insufficient annual payment updates, the proposed 340B drug payment cut discussed above, and continued site-neutral expansion. These facilities operate on the narrowest of margins,[7] and a faster recoupment schedule places many at heightened risk of service line elimination or closure.

NRHA does not believe the proposed repayment timeframe and a CY 2027 implementation start are appropriate. CMS states the proposed 3% reduction is intended to more closely align the repayment amount and timeframe to the amount and period over which hospitals actually received the increased payments from 2018 through 2022. NRHA notes that this period was an especially volatile one for

[7] Lauree Handlon, et al., Trends in hospital administrative costs: urban-rural disparities, barriers, and reduction strategies, Health Affairs Scholar, Aug. 8, 2025, https://doi.org/10.1093/haschl/qxaf149.

rural hospitals, marked by the COVID-19 pandemic, wage index disruptions, and elevated inflation. Applying the same repayment parameters nearly a decade later, without accounting for the very different environment rural hospitals now face is arbitrary and does not reflect current conditions. The redistributed 340B savings from 2018 to 2022 were essential to helping hospitals remain operational during the COVID-19 pandemic. Rural PPS hospitals used those funds to maintain staffing levels, stabilize supply chains, and continue providing care during unpredictable COVID surges. These funds were not placed in reserves; they were used to meet urgent public health needs. The originally proposed 0.5% recoupment over 16 years, while difficult, offered a manageable glidepath and time for rural hospitals to prepare for the recoupment. Increasing that rate to 3% with only a few months' notice may be destabilizing to vulnerable rural hospitals in CY 2027 and beyond.

**NRHA urges CMS to revert to the originally finalized 16-year schedule and given the significant strain rural providers face and to consider eliminating rural hospitals from the recoupment process altogether to preserve rural health care access.**

## VIII. Payment for Partial Hospitalization (PHP) and Intensive Outpatient Services (IOP).

### *C. Proposed CY 2027 Payment Rates for PHP and IOP.*

**NRHA appreciates CMS' continued investment in behavioral health and substance use disorder treatment services through the OPPS and supports CMS' payment update.** IOP services may be furnished in hospital outpatient departments, rural health clinics (RHCs), Community Mental Health Centers (CMHCs), and Federally Qualified Health Centers (FQHCs). CMS proposes to maintain the CY 2026 payment methodology, under which CMHC per diem rates are set at 40% of hospital-based rates, and projects an 8.4% increase in overall CY 2027 payments to CMHCs relative to CY 2026. NRHA supports this proposal, which we believe will help sustain rural behavioral health access, and we ask CMS to finalize it as proposed.

## IX. Services That Will Be Paid Only as Inpatient Services.

### *C. Proposed CY 2027 Changes to IPO List.*

CMS proposes to continue phasing out the IPO list, removing 637 services for CY 2027 spanning the auditory, digestive, endocrine, female genital, hemic and lymphatic, integumentary, male genital, maternity care and delivery, mediastinum and diaphragm, respiratory, and urinary clinical families. The remaining 801 more clinically complex procedures would move off the IPO list in the final transition year, CY 2028.

As in prior years, **NRHA urges CMS not to finalize this continued phase-out of IPO services.** Removing services from the IPO list eliminates a regulatory anchor that has helped protect against inappropriate Medicare Advantage claims denials and downcoding for medically complex procedures. Many of the affected services are higher-acuity procedures that generate meaningful inpatient revenue, even where they are not frequently performed in rural settings. Shifting them to OPPS generally means lower payment rates, which can erode margins, especially for rural and safety-net hospitals already operating on thin financial edges. Fixed costs do not shrink when care shifts settings; instead, hospitals still carry the overhead of inpatient capacity, including staffing, call coverage, equipment, and regulatory requirements, even as more procedures migrate to outpatient. Rural hospitals, particularly low-volume facilities, may be disproportionately affected where they lack the specialized staff, equipment, or post-acute support to safely manage same-day discharges for medically complex, older, or socially vulnerable patients. **NRHA asks CMS to ensure that any**

**continued transition includes clear clinical criteria, guardrails, and quality monitoring so financial incentives do not inadvertently push higher-risk patients into outpatient settings.**

## X. Nonrecurring Policy Changes.

### *A. Method To Control Unnecessary Services Furnished in Excepted Off-Campus Provider-Based Departments (PBDs).*

CMS proposes to expand its site-neutral payment policy by applying Medicare Physician Fee Schedule-equivalent rates to imaging without contrast services, including x-ray, ultrasound, CT, MRI, DEXA bone density, and mammography, furnished in excepted off-campus provider-based departments. CMS proposes to exempt rural SCHs from this policy, allowing their excepted off-campus PBDs to continue billing at the full OPPS rate at 107.1%, reflecting the rural SCH adjustment, but again declined to extend the exemption to other rural provider types, including REHs, LVHs and MDHs, citing a lack of historical cost data to support a similar adjustment.

**NRHA opposes further expansion of site-neutral payment policy for all hospitals.** Basic diagnostic imaging is a critical service point in rural communities and reducing payment risks further destabilizing rural hospitals' already narrow margins. At a minimum, **NRHA asks CMS to extend the exemption it is proposing for rural SCHs to REHs, MDHs and LVHs, all of which face the same low-volume, high-fixed-cost challenges as SCHs.** To the extent CMS believes it lacks the historical cost data necessary to support extending the exemption to these facility types, **NRHA asks CMS to begin collecting that data so an exemption can be adopted in future rulemaking.**

### *C. Adjustment for Cost-of-Living in Alaska and Hawaii.*

CMS proposes to establish a new cost-of-living adjustment (COLA) applying to the nonlabor share of outpatient hospital service payments in Alaska and Hawaii, mirroring the COLA applied to inpatient hospital services under the IPPS. The policy is proposed to be budget neutral across OPPS and is projected to increase payments to hospitals in these two states by $55 million in CY 2027. **NRHA supports this proposal and asks CMS to finalize it as proposed, given the unique cost circumstances facing rural providers in Alaska and Hawaii.**

## XII. MedPAC Recommendations.

### *D. Proposed Modification to the Overall Hospital Quality Star Rating Methodology.*

CMS acknowledges MedPAC's March 2026 recommendation to redistribute current Medicare safety-net payments like DSH and uncompensated care payments using MedPAC's proposed Medicare Safety-Net Index (MSNI), along with a recommended $1 billion addition to that funding pool to protect safety-net hospital viability. CMS states it will continue working with Congress on this issue, and no new MSNI policy is proposed in this rule.

While NRHA recognizes implementing the MSNI is ultimately a matter for Congress, **NRHA encourages CMS to continue supporting adoption of the MSNI framework and the additional $1 billion in funding MedPAC has recommended.** As CMS and Congress continue to develop this policy, NRHA urges continued attention to how the MSNI's design accounts for the unique circumstances of rural safety-net hospitals, and we would welcome the opportunity to provide further input as this policy develops.

## XX. Codification of Section 6225 Consolidated Appropriations Act, 2026 for the Requirements for Provider-Based Status.

CMS proposes to implement Section 6225 of the Consolidated Appropriations Act (CAA), 2026, which, beginning January 1, 2028, will prohibit OPPS payment for off-campus outpatient departments of a provider unless the department bills under a separate National Provider Identifier (NPI) and the main provider has submitted a compliant provider-based attestation for that department. To meet this requirement, hospitals must, for each off-campus department, (1) file a provider-based attestation covering the two years preceding January 1, 2028, and (2) obtain and use on Medicare claims a separate NPI for that location. Failure to comply results in the off-campus department no longer being treated as part of the hospital's provider-based operations, with loss of associated payment status. Locations that do not comply with all Medicare provider-based rules will be unable to attest to compliance and, upon discovery of any noncompliance, hospitals must evaluate corrective actions, including potential return of overpayments. As proposed, this requirement does not apply to RHCs, which remain excluded from the definition of a "department of a provider" for this purpose. CMS did not clarify the definition of "department" or whether it will modify the current requirement to bill Medicare before submitting an attestation, leaving open whether new off-campus outpatient locations can be opened after December 31, 2027.

NRHA appreciates the opportunity to comment on this new compliance requirement, which may carry substantial administrative burden and legal exposure for rural hospitals. Because attestations must retrospectively cover the two years preceding January 1, 2028, and because a hospital that should have attested but did not may face significant overpayment and False Claims Act exposure for payments received in the interim, rural hospitals need clear, timely guidance well in advance of the deadline. **NRHA asks CMS to finalize the standardized attestation form and supporting documentation categories as early as possible, and to phase or prioritize documentation requirements rather than requiring all categories including licensure, clinical integration, financial integration, public awareness, outpatient department obligations, and ownership, control, administration, and supervision at once.**

***Provider-Based RHCs.*** **NRHA urges CMS to consider the need for written guidance in regard imaging services, primarily x-rays, furnished in connection with provider-based RHCs.** For years, many hospitals have billed such imaging services through the main hospital as if furnished in a hospital outpatient department, without significant CMS oversight. As CMS has moved toward more granular, location-specific reporting and enforcement for off-campus hospital outpatient departments, it has left off-campus RHC-affiliated imaging in a regulatory gray area, with no written CMS guidance addressing how these services should be enrolled or billed despite repeated requests from stakeholders. The prevailing industry recommendation, that hospitals with provider-based RHC imaging enroll those locations as hospital outpatient departments and bill and comply accordingly, is followed by only a small share of affected hospitals today, in part because of this lack of guidance.

**NRHA would appreciate written clarification that off-campus provider-based RHCs, including the imaging services they provide, are not subject to Section 6225.** While provider-based RHC imaging services may be billed under the parent hospital's CCN, they are furnished inside the four walls of an RHC, not an off-campus hospital department, and should be treated accordingly.

This gap now carries heightened stakes under the new provider-based attestation requirements. A hospital that CMS later determines should have filed an attestation, was therefore receiving OPPS-level payment for advanced imaging it should not have been, then faces False Claims Act risk. **NRHA**

**urges CMS to issue clear written guidance on how RHC-affiliated imaging services should be enrolled and billed**, and to work with Congress, as needed, to update the statutory RHC payment structure to explicitly address imaging which would provide rural hospitals and RHCs the clarity and financial framework they currently lack.

**NRHA recommends CMS adopt a targeted, low-burden processing fix to reduce ambiguity for RHC locations under the new attestation and site-neutral payment framework by adding RHC locations to the list of off-campus locations a hospital must report on Form CMS-855A**, allowing the hospital to identify a location as an RHC. Flagging RHC locations on the 855A would allow CMS to exclude those locations from OPPS site-neutral payment policies and from the new provider-based attestation cross-reference by default and could be accomplished through CMS processing instructions rather than a CFR citation. This approach would reduce burden for hospitals, give CMS greater visibility into RHC-furnished services, and would be a comparatively modest lift for CMS to implement, since it functions as a payment-processing clarification rather than a substantive policy change.

***Mobile Units and De Minimis Locations.*** CMS specifically requests comment on locations that should be exempt from the provider-based attestation and separate-NPI requirements, including mobile units and locations with de minimis or infrequent billing of items or services paid under OPPS. **NRHA supports exempting both categories.** Mobile units, by their nature, do not operate from a single fixed off-campus location in the way the attestation and NPI framework contemplates; requiring a hospital to attest to, and obtain a separate NPI for, a location that moves is impractical and does not meaningfully advance the policy's underlying purpose of ensuring accurate site-of-service billing. Given the low-volume of services frequently provided in rural areas, NRHA similarly supports exempting locations with de minimis or infrequent OPPS billing, where the administrative burden of attestation and separate NPI enrollment would be disproportionate to the volume of affected payments.

***Other RFI Issues.*** On the broader set of items CMS raises for comment including subsequent attestation cadence, treatment of departments with pre-2026 provider-based determinations, the standardized attestation form, and the verification and oversight process, NRHA offers the following solutions.

1) NRHA supports capping the interval for subsequent attestations at no more than five years, as CMS proposes, and **asks CMS to allow rural hospitals additional lead time to prepare for each attestation cycle.**
2) NRHA supports not requiring a new, mandatory initial attestation for departments that already received a CMS provider-based determination before January 1, 2026 and remain compliant with § 413.65, to avoid duplicative burden for hospitals CMS has already reviewed.
3) **NRHA urges CMS to adopt a risk-based, rather than blanket, review approach, relying on automated validation and documentation review** before escalating to remote audits, site visits, or investigations, given rural hospitals' limited administrative capacity to respond to broad-based verification requests.

NRHA thanks CMS for including RFI-style questions on the operational feasibility and burden of this requirement, and we welcome the opportunity to provide additional data and examples as CMS finalizes this policy.

## XXII. Consideration of Potential Approaches for Separate IPPS Payment for Domestic Procurement of Personal Protective Equipment and Essential Medicines

NRHA appreciates CMS' attention to persistent drug and medical supply shortages, which disrupt patient care and disproportionately affect rural hospitals and the patients they serve. Rural hospitals face heightened exposure to shortages with smaller purchasing volumes that leave them with less leverage with wholesalers and manufacturers, fewer local or regional alternative suppliers to turn to, and limited pharmacy staff capacity leaves little room to manage the complex sourcing workarounds that larger health systems can absorb. NRHA offers the following recommendations to help ensure that any domestic procurement incentive meaningfully improves rural patient access to essential medicines.

NRHA urges CMS to prioritize medicines and supplies most likely to disrupt rural patient care if a shortage occurs, using a data-driven methodology that accounts for therapeutic importance, shortage history, and manufacturing concentration. Rural service line closures, most notably chemotherapy, are often among the first casualties when rural hospitals face financial astrain.[8] **Essential medicines used in these and other high-acuity rural service lines should be a priority focus for any domestic manufacturing incentive**.

**NRHA encourages CMS to pair any domestic manufacturing incentive with procurement and purchasing practices that reward supply reliability, not solely lowest acquisition cost.** Rural hospitals are the least able to absorb price volatility or last-minute sourcing disruptions during a shortage, so payment models that reward manufacturing quality, supplier diversification, and reliable production would disproportionately protect rural patient access.

NRHA cautions CMS that domestic manufacturing of a finished dosage form does not, on its own, guarantee supply chain resilience, as many domestically finished medicines continue to depend on concentrated foreign sources for active pharmaceutical ingredients (APIs) and key starting materials. **NRHA encourages CMS to adopt a comprehensive definition of domestic manufacturing that accounts for these upstream dependencies**, and to consider, over time, how payment and procurement incentives could further strengthen resilience across the full manufacturing supply chain, including APIs and key starting materials.

## XXIII. Request for Information on Strengthening the Standardization and Comparability of Hospital Price Transparency (HPT) Data.

Since January 1, 2021, CMS has required each hospital to provide clear, accessible pricing information online via 1) a comprehensive machine-readable file (MRF) and 2) a consumer-friendly display. Consistent with Executive Order 14221, CMS is including an RFI to seek public comment on potential approaches to improve HPT data consistency, comparability, and consumer usability, including potential mechanisms to strengthen MRF requirements, the reporting of contract mechanisms, and approaches to enhance the consumer-friendly display requirements.

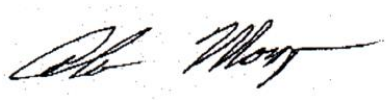
**NRHA asks CMS to ensure any future MRF or consumer-display standardization requirements account for rural hospitals' limited administrative and software capacity.** Rural hospitals

8 Michael Topchik, et al., *2026 rural health state of the state*, Chartis Center for Rural Health (2026), https://www.chartis.com/insights/2026-rural-health-state-state.

already face significant compliance challenges under the existing HPT rule: a 2024 OIG audit found that 46% of all hospitals failed to post required standard charge data, reflecting widespread difficulty even with current requirements,[9] and rural hospitals allocate 18% more of their total expenses to administrative salaries compared to urban peers.[10] Adding new layers of complexity, such as additional required MRF elements or more granular contracting methodology reporting, would disproportionately burden rural hospitals that often lack the dedicated software or staff to compile and maintain this data. **NRHA asks CMS to consider a simplified compliance pathway or exemption for rural hospitals as it develops any future standardization requirements arising from this RFI.**

Thank you for the opportunity to comment on this proposed rule. We look forward to continuing to work together towards our mutual goal of improving health care and access for rural Americans. If you have any questions or would like to discuss further, please contact NRHA's Chief Policy Officer, Carrie Cochran-McClain at ccochran@ruralhealth.us.

Sincerely,



Alan Morgan
Chief Executive Officer
National Rural Health Association

[9] Office of the Inspector General, Department of Health and Human Services, Not All Selected Hospitals Complied With The Hospital Price Transparency Rule (Nov. 2024), https://oig.hhs.gov/documents/audit/10042/A-07-22-06108.pdf.
[10] Lauree Handlon, et al., Trends in hospital administrative costs: urban-rural disparities, barriers, and reduction strategies, Health Affairs Scholar, Aug. 8, 2025, https://doi.org/10.1093/haschl/qxaf149.