National Rural Health Association

July 21, 2026

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

RE: CMS-2449-P; Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments

Comment submitted electronically via regulations.gov

Dear Administrator Oz,

The National Rural Health Association (NRHA) is pleased to submit comments on the Centers for Medicare and Medicaid Services' (CMS) proposed rule, "Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments" (CMS-2449-P; 91 FR 30400). NRHA appreciates CMS's effort to provide regulatory clarity regarding the implementation of these statutory changes; however, we have significant concerns about aspects of this proposed rule that would disproportionately harm rural hospitals and jeopardize Medicaid enrollee access to care in rural communities.

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 (CAH), long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

State-directed payments have served as a critical mechanism for ensuring that rural hospitals and other rural safety-net providers receive Medicaid payment rates sufficient to sustain access to care for Medicaid enrollees. In many states, SDPs have been the primary tool through which Medicaid managed care payments to rural hospitals have been brought closer to the actual cost of care. Without adequate SDP support, many rural hospitals would face Medicaid payment rates that fall well below their costs, threatening their financial viability and the communities they serve.

Rural hospitals serve a disproportionately high share of Medicaid and uninsured patients,[1, 2, 3] operate with thin or negative operating margins, and often provide services at a loss because they are the only available provider of essential care in their communities. Nearly 50 percent of rural hospitals are currently operating with negative margins, and the median operating margin for rural hospitals is approximately 1%.[4] More than 200 rural hospitals have closed or ceased inpatient services since 2010, and an additional 432 hospitals are currently at risk of closure.[5] The financial pressures created by

[1] Kaiser Family Foundation. *Health Care in Rural America*. KFF; 2023. Accessed July 17, 2026. https://www.kff.org
[2] Medicaid and CHIP Payment and Access Commission. *Medicaid in Rural America*. MACPAC; 2021. Accessed July 17, 2026. https://www.macpac.gov/publication/medicaid-in-rural-america/
[3] Thomas SR, Holmes GM, Pink GH. Financial distress and closure of rural hospitals. *J Rural Health*. 2020;36(1):22-32. doi:10.1111/jrh.12385
[4] Chartis Center for Rural Health, Rural Hospital Closures & Care-Access Crisis: 2025 State of the State (Feb. 2025), https://www.chartis.com/insights/2025-rural-health-state-state.
[5] Id.

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inadequate reimbursement rates are a central driver of this crisis, and SDPs have played a meaningful role in mitigating those pressures in states that have used them effectively.

In addition to rural hospitals, SDPs are a critical tool that enables states with the flexibility to direct targeted supplemental payments for needed services such as behavioral health providers, home and community-based service providers, dental providers, nursing facilities, and other safety-net organizations. SDPs also allow states to advance policy goals such as improving quality, expanding access, and addressing workforce shortages. Of note, Medicaid SDPs have been an important tool for enabling states to advance value-based payment (VBP) efforts in managed care delivery systems, a key element of the movement towards rewarding value for the Centers of Medicare & Medicaid Services.

Beyond the direct effect on rural hospitals and other rural providers, NRHA is concerned that these payment limits could also affect the willingness and ability of Medicaid managed care plans to maintain adequate rural provider networks. If SDP-supported payment levels fall as a result of the new caps, plans may find it more difficult to contract with rural providers on terms sufficient to sustain their participation in Medicaid managed care, which would in turn reduce the number and adequacy of rural providers available to Medicaid enrollees.

NRHA therefore approaches this proposed rule with serious concern. The combination of statutory rate caps enacted in H.R. 1 and the additional regulatory proposals in this rule, particularly the extension of caps to services not specified in the statute and the prohibition on uniform rate increases, risk compounding financial pressures on rural providers.

II. Provisions of the Proposed Regulations

1. Payment Limits for SDPs

CMS proposes to define "total published Medicare payment rate" as the exact total published Medicare payment rate for a specific service furnished to a Medicaid managed care enrollee, calculated at the service or discharge level, whether at the HCPCS code level or for Medicare Severity Diagnosis-Related Groups (MS-DRGs) as used under the Medicare IPPS.[6]

b. Regulatory Revisions for Other SDPs, Services and Territories

Definitions

CMS's proposed methodology establishing the SDP payment limit for hospitals reimbursed on a cost basis raises significant operational concerns. Under the proposed rule, CMS would require states to derive a prospective, service- or discharge-specific payment limit for CAHs using the hospital's most recent Medicare cost report, applying cost allocation methodologies to translate facility-level cost data into service-level payment amounts. Unlike the Medicare Physician Fee Schedule or IPPS payment rates, which are published and updated on a predictable schedule, CAH cost reports are retrospective, filed on a rolling basis, and not designed to generate discrete, service-specific payment figures. States would therefore need to build new modeling capacity simply to identify a compliant payment limit for CAH-inclusive SDPs, a burden CMS does not impose on states operating SDPs for prospective-paid hospitals.[7]

NRHA appreciates that CMS rejected the two alternative approaches it considered, which were to rely solely on Medicare rates set through notice-and-comment rulemaking, or exclude cost-based

[6] 91 Fed. Reg. 30400, 30411 (May 22, 2026); Proposed 42 C.F.R. § 438.6(a) (definition of "Total published Medicare payment rate").
[7] 91 Fed. Reg. at 30414.

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reimbursement from the definition of total published Medicare payment rate, because either alternative would have produced payment limits well below the actual cost of providing care at CAHs. [8] However, **NRHA urges CMS to work with states and CAHs to develop a standardized, transparent cost-allocation methodology before finalizing this provision, and to provide a reasonable transition period recognizing that CAH cost report data often lags by one or more years.**

Payment Limits

Section 71116 of H.R. 1 limits the Medicare-based payment cap to four specific service categories: inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at academic medical centers.[9] The proposed rule goes considerably further, extending the same Medicare-based payment limit to every SDP, for every covered service, in every state, the District of Columbia, and the territories, beginning with rating periods on or after January 1, 2029.[10] CMS estimates that the combined statutory and regulatory changes in this rule will reduce federal Medicaid spending by $510.1 billion from 2026 through 2035[11], more than three times the reduction the Congressional Budget Office projected when it scored Section 71116 alone.[12] That gap suggests CMS is using this rulemaking to reach far beyond the scope of the changes Congress enacted.

For rural communities, this extension is especially consequential because many state SDPs that support rural providers are not built around the four statutorily capped service categories. States such as Louisiana[13], Mississippi[14], Arizona[15], New York[16], and Texas[17] have all developed SDP-funded programs specifically to support rural hospitals and CAHs, including enhanced reimbursement funds, rural hospital inpatient funds, and CAH- and sole-community-hospital-specific directed payment programs, several of which reach services or provider types outside the four listed categories. Subjecting these programs to a Medicare-based cap that Congress did not require would undercut state-designed mechanisms that have helped keep rural facilities financially viable. NRHA urges CMS to limit the payment cap to the four service categories specified in the statute and to refrain from extending the limit to all SDPs, all service types, and the territories absent clear statutory direction to do so.

Further, NRHA is concerned about the impact of extending the payment limit to all SDP-covered services on home and community-based services (HCBS) and other services for which Medicare does not set a payment rate. Because Medicare covers a narrower set of benefits than Medicaid, many rural HCBS and long-term services and supports included in state SDPs would default to a payment limit equal to 100

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[8] Id.
[9] Pub. L. No. 119-21, § 71116(a) (2025).
[10] 91 Fed. Reg. at 30424-25.
[11] 91 Fed. Reg. at 30451.
[12] Congressional Budget Office, Supplemental Cost Estimate, Public Law 119-21, at 5 (Oct. 28, 2025), https://www.cbo.gov/system/files/2025-10/PL-119-21-Medicaid%20_0.pdf.
[13] Louisiana Department of Health, Directed Payment Preprint, LA_Fee_IPH.OPH2 (rating period July 1, 2025 – June 30, 2026), https://www.medicaid.gov/medicaid/managed-care/downloads/LA_Fee_IPH.OPH2_New_20250701-20260630.pdf.
[14] Mississippi Division of Medicaid, Rural Hospital Ambulatory Payment Classification (APC) Opt-Out Program, https://medicaid.ms.gov/value-based-incentives/.
[15] Arizona Health Care Cost Containment System, Rural Hospital Inpatient Fund, https://www.azahcccs.gov/PlansProviders/RatesAndBilling/RHIF.html.
[16] CMS, Approved State Directed Payment Preprints (New York), https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/approved-state-directed-payment-preprints?search_api_fulltext=ID:155646.
[17] Manatt Health, Stabilizing Rural Safety-Net Hospitals, https://www.manatt.com/insights/newsletters/health-highlights/stabilizing-rural-safety-net-hospitals.

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percent of the state plan approved rate,[18] eliminating states' ability to use SDPs to bring managed care payments for these services above the state's own base rate. This would be particularly harmful in rural areas, where limited provider capacity already makes it difficult to sustain HCBS networks and where SDPs have often been the primary lever states to use to attract and retain providers of these services.[19]

For the reasons discussed above, **NRHA urges CMS to revert to the four service categories enumerated in Section 71116 of H.R. 1, inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at academic medical centers, rather than extending the payment limit to all SDP-covered services.**

NRHA also notes that, unlike grandfathered SDPs, the extension of the payment limits to all other SDPs includes no phase-down period at all. States must reduce any SDP above the limit to comply by the first rating period beginning on or after January 1, 2029.[20] Pairing an already aggressive expansion of scope with an all at once compliance requirement compounds the disruption for rural providers relying on these SDPs, many of whom would otherwise have benefited from a transition comparable to the grandfathering framework Congress provided for the four statutory service categories. NRHA urges CMS to provide a reasonable phase-down period for any SDP newly brought within the payment limit as a result of the rule's expanded scope, consistent with the treatment afforded grandfathered SDPs.

c. Payment Limit Monitoring and Compliance

The proposed rule would require states to submit substantial new documentation for every SDP, including a list of all eligible providers and their National Provider Identifiers (NPIs), the total published Medicare payment rate or state plan approved rate applicable to each covered service, and a detailed description of how the state will ensure that payment to each provider does not exceed the payment limit. States implementing value-based payment SDPs would face an additional requirement to submit a detailed validation methodology demonstrating that VBP arrangements do not exceed the per-service payment limit.[21] Taken together with the claims-level Medicare pricing analysis CMS's proposed payment limit methodology already requires, these new reporting obligations represent a substantial increase in administrative burden for state Medicaid agencies, many of which are already resource-constrained.

NRHA is concerned that states, particularly smaller, state Medicaid agencies with limited staff capacity in predominately rural states, will struggle to meet these requirements on the proposed timeline, which could in turn delay approval of SDPs that rural hospitals depend on. **NRHA urges CMS to provide technical assistance and model reporting templates to states in advance of the compliance deadlines, and to build in a reasonable implementation runway before enforcing the new monitoring and validation requirements.**

<u>Value-Based Payment SDPs</u>

NRHA urges CMS to withdraw its proposal to apply the Medicare-based payment limit, and the accompanying per-service validation methodology requirement, to SDPs structured as value-based payment (VBP) arrangements. VBP SDPs are designed differently from traditional fee-for-service SDPs, rewarding providers for quality outcomes, care coordination, or performance improvement rather than

[18] 91 Fed. Reg. at 30411-13; Proposed 42 C.F.R. § 438.6(a) (definition of "Payment limit").
[19] NORC at the University of Chicago. *Home and Community-Based Services Landscape Analysis & Model Case Studies*. The Commonwealth Fund; March 2026. Accessed July 17, 2026
[20] 91 Fed. Reg. at 30425, 30427; Proposed 42 C.F.R. § 438.6(c)(2)(ii).
[21] Proposed 42 C.F.R. § 438.6(c)(8).

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simply directing a fixed payment per service. Requiring states to demonstrate, on a per-service basis, that VBP payments do not exceed the Medicare-based limit would undermine the flexibility states need to design meaningful incentive payments for high-value care, particularly in rural areas where providers are still building the infrastructure needed to succeed under alternative payment models.

To preserve flexibility for states to implement VBP models, CMS should shift its focus from provider and service-code-specific limits and instead consider overall costs to states and the federal government. This approach would allow states to target payments to providers who provide access to quality care. In addition, CMS should consider exceptions to Medicare-based limits for value-based payment models that can demonstrate cost effectiveness in other ways. Further, CMS should also ensure that efforts to regulate SDPs do not interfere with the ability of MCOs to negotiate their own VBP models with providers. In particular, we are concerned that CMS' proposal to prohibit uniform rate increase SDPs will require states to adopt minimum fee schedules that reduce the ability of MCOs to negotiate their own payment policies with providers to reward value-based care. **NRHA urges CMS to preserve state flexibility to design and implement VBP SDPs that reward high-value care without subjecting them to the same per-service payment limit methodology applied to traditional SDPs.**

2. Grandfathered SDPs

a. Definition of a Grandfathered SDP

NRHA has significant concerns with how the proposed rule defines grandfathered status. First, the eligibility criteria are unnecessarily narrow: only SDPs for one of the four statutorily capped services, and that meet a specific preprint-submission and rating-period timing window, qualify for temporary grandfathered treatment.[22] Longstanding rural-specific SDPs that do not happen to fall within one of the four service categories receive no transition relief at all and must comply with the new payment limits immediately, even though they may be just as essential to rural provider viability as an SDP for, say, inpatient hospital services. **NRHA urges CMS to extend grandfathered treatment, or an equivalent transition period, to any SDP that principally benefits rural hospitals or CAHs, regardless of the specific service category involved.**

Second, CMS has left unresolved whether and how a state may update a grandfathered SDP's provider eligibility criteria, payment methodology, or included services without jeopardizing its grandfathered status.[23] States need this flexibility to respond to changing rural provider needs over the multi-year grandfathering and phase-down period, and the current ambiguity will likely lead states to freeze SDP design rather than risk losing grandfathered treatment. NRHA asks CMS to clarify that routine administrative updates to a grandfathered SDP will not disqualify it from grandfathered status.

b. Temporary Grandfathering Period

NRHA is concerned about the brevity of the temporary grandfathering period itself. Grandfathered SDPs may continue at their grandfathered total dollar amount only through the rating period ending immediately before January 1, 2028, at which point the mandatory 10% annual phase down begins. For rural hospitals and CAHs that have built multi-year budgets and staffing plans around a grandfathered SDP, roughly two rating periods before phase-down beings is a short window to adjust to a materially lower payment ceiling. **NRHA urges CMS to extend the temporary grandfathering period for SDPs that principally benefit rural hospitals and CAHs, giving these providers additional time to plan for and adjust to the payment limit before the mandatory phase down begins.**

[22] 91 Fed. Reg. at 30418-20; Proposed 42 C.F.R. § 438.6(a) (definition of "Grandfathered State directed preprint").
[23] See 91 Fed. Reg. at 30420.

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c. Phase Down of Grandfathered SDPs

NRHA is concerned with CMS's proposed phase-down methodology, which calculates the required 10-percentage-point annual reduction as a share of the SDP's original grandfathered total dollar amount rather than as a percentage of the prior year's payment amount.[24] Because reductions do not compound, this approach can produce a materially different and, in some cases, more abrupt, phase-down trajectory than the percentage-of-payment-rate approach NRHA understood Section 71116 to contemplate. **NRHA urges CMS to reconsider this methodology and to model the practical effect on existing grandfathered SDPs, particularly those supporting rural hospitals, before finalizing the approach.**

3. Types of Permissible SDPs and Provider Classes

a. Minimum Fee Schedule SDPs and b. Maximum Fee Schedule SDPs

NRHA is concerned about CMS's proposal to restrict how states may structure minimum and maximum fee schedule SDPs beginning with the first rating period on or after January 1, 2028.[25] CMS proposes to apply this new restriction to rating periods beginning on or after July 9, 2024 but before January 1, 2028, meaning states must sort out which of their existing minimum and maximum fee schedule arrangements fall under the current, more flexible rules versus the new restrictions, potentially unsettling arrangements already in place. Under current regulations, states may adopt a minimum fee schedule based on Medicaid state plan approved rates without a preprint submission or prior written CMS approval, giving states an important, low-burden tool to bring managed care payments closer to actual provider costs.

The proposed rule would eliminate that flexibility, permitting states to adopt only a minimum or maximum fee schedule that does not exceed the same Medicare-based payment limit that applies to other SDPs. States would need to confirm, and in many cases amend, existing fee schedule arrangements to demonstrate compliance, and would need to complete that transition on an accelerated timeline that precedes the rule's own general compliance date by a full calendar year. For rural hospitals and CAHs that rely on state plan based minimum fee schedules to secure adequate managed care payment, this earlier and more restrictive timeline adds a new compliance burden layered on top of the broader payment limit changes. **NRHA urges CMS to align effective date for minimum and maximum fee schedule SDPs with the general payment limit's January 1, 2029, effective date, rather than requiring an earlier, separate transition.**

c. Uniform Increase SDPs

CMS proposes to eliminate uniform percentage or dollar increase SDPs entirely for rating periods beginning on or after January 1, 2028, requiring states to restructure these arrangements as minimum or maximum fee schedules instead.[26] Uniform increase SDPs have been a significant funding mechanism for rural and CAH-specific programs:

- South Carolina has used uniform increase SDP directing more than $2.5 billion to inpatient and outpatient hospital services at all in-network SC hospitals.[27]

[24] 91 Fed. Reg. at 30423.
[25] 91 Fed. Reg. at 30425; Proposed 42 C.F.R. § 438.6(c)(1)(iii)(A)-(B).
[26] 91 Fed. Reg. at 30427; Proposed 42 C.F.R. § 438.6(c)(2)(iii)(E).
[27] CMS, Approved State Directed Payment Preprint, SC_Fee_IPH.OPH_Renewal_20240701-20250630 (South Carolina), https://www.medicaid.gov/medicaid/managed-care/downloads/SC_Fee_IPH.OPH_Renewal_20240701-20250630.pdf.

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- Washington has used uniform increase SDPs to direct more than $2 billion to inpatient and outpatient hospital services at CAHs and PPS hospitals[28]
- Illinois has used a uniform increase SDP to direct $13.5 million to CAH outpatient services[29], and
- New Hampshire has used a uniform dollar increase to direct more than $56 million to CAH inpatient and outpatient services.[30]

Eliminating this SDP type entirely, rather than addressing CMS's stated concerns through more targeted guardrails, forces states to unwind and rebuild these programs at the same time they are managing compliance with the new Medicare-based payment limits and grandfathered SDP phase-downs.

NRHA urges CMS to withdraw this proposal and retain uniform increase SDPs as a permissible option, particularly for provider classes limited to rural hospitals and CAHs. At minimum, if CMS proceeds with this change, NRHA urges the agency to extend the effective date so that states are not required to restructure uniform increase programs in the same year that broader payment limit compliance obligations take effect.

e. Provider Classes

NRHA welcomes CMS's request for comment on how to define "provider class" for purposes of SDPs. CMS has expressed concern that states may be designing provider classes so narrowly that they appear correlated with the source of non-federal share financing rather than with the state's Medicaid managed care quality strategy. NRHA cautions CMS against adopting a definition of "provider class" that would discourage or disallow provider classes defined around rural-specific designations, such as CAHs, rural emergency hospitals, sole community hospitals, or rural health clinics (RHC).

These classifications are not merely proxies for financing arrangements; they reflect genuine, well-documented differences in cost structure, patient acuity, and access challenges that are directly germane to a state's Medicaid managed care quality strategy. A definition of provider class tied narrowly to categories already listed in the approved Medicaid state plan could inadvertently prevent states from directing payments to the rural-specific provider types most in need of support, particularly where the state plan does not already contain sufficiently granular rural designations. NRHA urges CMS to clarify that a provider class limited to rural hospital or CAH status is inherently consistent with, and germane to, a state's Medicaid managed care quality strategy, given the well-established relationship between rural provider financial stability and beneficiary access to care.

B. Targeted Medicaid Payment Limit in an FFS Delivery System

CMS's proposed limit on targeted Medicaid FFS payments, capping targeted base and supplemental payments at the same Medicare-based percentages that apply to SDPs, would apply to a range of payments rural providers rely on, including targeted payments to physicians, dentists, and non-emergency medical transportation providers.[31] NRHA appreciates that CMS excludes payments that are uniform across all providers in a geographic region, preserving states' ability to make rural-wide

[28] CMS, Approved State Directed Payment Preprints (Washington), https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/approved-state-directed-payment-preprints.
[29] CMS, Approved State Directed Payment Preprints (Illinois), https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/approved-state-directed-payment-preprints.
[30] CMS, Approved State Directed Payment Preprints (New Hampshire), https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/approved-state-directed-payment-preprints.
[31] Proposed 42 C.F.R. § 447.381; 91 Fed. Reg. at 30431-34.

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targeted payments without a cap. However, NRHA is concerned that the rule offers no phase-down period for targeted FFS payments, in contrast to the multi-year grandfathering and phase-down structure afforded to SDPs. States and providers would need to come into compliance by the first state fiscal year beginning on or after January 1, 2029.

NRHA supports CMS's proposal to exempt from the targeted payment limit those services already subject to an existing regulatory or statutory payment limit, including the statutory prospective payment system floor that applies to RHCs and federally qualified health centers (FQHCs). RHCs and FQHCs are often the only source of primary care in rural communities, and their statutory payment floor is critical to sustaining access in areas that would otherwise struggle to attract and retain primary care providers. NRHA urges CMS to preserve this exemption in the final rule and to confirm explicitly that no aspect of the targeted payment limit may be construed to reduce RHC or FQHC payments below their statutory PPS floor.

NRHA is concerned about how the targeted payment limit would apply to the combined total of base and supplemental payments. Under the proposed rule, if a state proposes a supplemental payment available only to a subset of practitioners, the payment limit applies to the full combined total of the base payment plus the supplemental payment, even though only a portion of that total is targeted. This aggregation approach could constrain states' ability to use supplemental payments as a meaningful tool to support rural-serving practitioners, particularly where base payment rates are already close to the Medicare-based limit, leaving little or no room for a supplemental add-on. NRHA urges CMS to clarify how this aggregation rule is intended to operate and to consider alternatives that would preserve states' ability to make meaningful supplemental payments to rural-serving practitioners without being constrained by the combined base-plus-supplemental ceiling.

Given that many of these targeted payment arrangements, particularly for rural EMS and non-emergency medical transportation providers funded through intergovernmental transfers, have been in place for years and are built into state budgets and provider operations, an abrupt transition risks disrupting services with little warning. For these reasons, NRHA urges CMS to withdraw this provision in its entirety. If CMS nonetheless proceeds with a Medicare-based limit on targeted Medicaid FFS payments, NRHA urges the agency to consider alternatives it did not include in the NRPM, such as a phased compliance period for targeted FFS payments comparable to the SDP phase-down, particularly for rural-serving provider types.

NRHA is also concerned about the complexity and rural impact of how CMS proposes to calculate the comparable Medicare rate for the targeted FFS payment limit. The Medicare Physician Fee Schedule and Ambulance Fee Schedule, which would serve as the basis for this limit, pay different rates depending on geography, site of service, and provider type, and states would bear the burden of correctly applying all of these variables when setting a compliant targeted payment. This is particularly consequential for rural communities, which rely heavily on nurse practitioners, physician assistants, and other non-physician practitioners to deliver primary and specialty care. Because Medicare generally pays non-physician practitioners at a reduced percentage of the full Medicare PFS rate, the proposed limit would cap targeted Medicaid payments for these practitioner types at a correspondingly lower amount, as low as 85 percent of the full Medicare PFS amount in expansion states and 93.5 percent in non-expansion states. Given that non-physician practitioners are often the primary, or only, source of care in rural communities, this reduced ceiling could constrain states' ability to adequately compensate these practitioners through targeted payments, undermining access at precisely the point of care rural Medicaid enrollees rely on most. NRHA urges CMS to account for this dynamic in the final rule and to ensure that the targeted payment limit does not create a disincentive for states to adequately support non-physician practitioners in rural and underserved areas.

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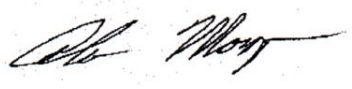
Thank you for the opportunity to respond to this proposed rule. We look forward to working together to protect rural patients and providers across the country. If you have any questions or would like further information, please contact NRHA's Senior Government Affairs and Policy Coordinator, Marguerite Peterseim (mpeterseim@ruralheath.us).

Sincerely,



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