National Rural Health Association

September 10, 2025

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

RE: CMS-1834-P; Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency

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) 2026. We appreciate CMS' continued efforts to update payment systems and improve quality and transparency, while recognizing the unique challenges faced by rural hospitals. 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, 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, 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% payment rate increase for hospitals under OPPS for CY 2026, based on a projected 3.2% hospital market basket increase and a 0.8% productivity adjustment. NRHA thanks CMS for the payment update but we are concerned that this update is not enough to keep rural hospitals sustainable.

NRHA remains alarmed about the discrepancy between Medicare payment rates and actual inflation. This increase is significantly below the actual inflation rural hospitals face. As of June 2025, the Consumer Price Index for hospital services was 4.2% meaning that Medicare reimbursement will continue to fall behind the actual cost of providing care to beneficiaries.[1] Compounding CMS' underpayment, rural hospitals and health systems also face labor and supply cost pressures and

[1] Press Release, Bureau of Labor Statistics, Department of Labor, Consumer Price Index – June 2025 (Aug. 6, 2025), https://www.bls.gov/news.release/pdf/cpi.pdf.

workforce shortages. The projections that CMS uses for updating payment rates have recently been lower than actual inflation because historical data is used. Using historical inflation data leads to inadequate payment updates. **It is critical that CMS explores how it can accurately pay rural hospitals by accounting for current inflation rates and historical underpayment.** Since 2010, 196 rural hospitals have closed or ceased inpatient services, the majority of which were PPS hospitals.[2] Estimates show that an additional 432 rural hospitals are vulnerable to closure.[3]

Closures are only one measure of hospital financial instability. Over half of rural hospitals are operating in the red.[4] The median operating margin for independent rural hospitals is 1.0% and the median for system-affiliated rural hospitals is 1.7%.[5] When hospitals are operating with low or negative margins they often cut less profitable yet important service lines, most notably obstetrics or chemotherapy, leaving rural beneficiaries without a local point of access to care. **We urge CMS to finalize higher payment rates for CY 2026 to help sustain access to care for Medicare beneficiaries in rural communities.**

NRHA supports CMS' proposed continuation of the 7.1% payment adjustment for rural sole community hospitals (SCHs). We ask CMS to finalize this policy as proposed. We also ask that CMS consider extending this payment increase to Medicare Dependent Hospitals (MDHs), which by definition are like hospitals. We also ask that CMS consider extending this payment increase to Medicare Dependent Hospitals (MDHs), which by definition are like rural hospitals. They face many of the same challenges providing care to rural patients as SCHs, like low patient volumes, a sicker patient mix, and high reliance upon 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.**

NRHA recommends CMS perform a study to look at the costs that MDHs incur and make an adjustment similar to what SCHs receive to help support the rural health safety net. Since 2010, 29 MDHs have closed their doors.[6] The Government Accountability Office (GAO) likewise found that Medicare profit margins 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.[7] The degree to which Medicare margins declined for MDHs during this time period (6%) was greater than the degree to which they

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[2] 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/; 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).

[3] Michael Topchik, et al., *2025 rural health state of the state*, Chartis Center for Rural Health (2025), 2 https://www.chartis.com/sites/default/files/documents/CCRH%20WP%20-%202025%20Rural%20health%20state%20of%20the%20state_021125.pdf.

[4] *Id.*

[5] *Id.* at 2-3; Zachary Levinson, et al., *Key Facts About Hospitals: Rural Hospitals*, KFF, Feb. 19, 2025, https://www.kff.org/key-facts-about-hospitals/?entry=rural-hospitals-rural-discharges-by-payer.

[6] N.C. Rural Health Research Center, *supra* note 2.

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

declined for rural hospitals (3.8%) and all hospitals (2.5%).[8] **NRHA contends that MDHs need the same financial support through OPPS payment adjustments as SCHs.**

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

B. Proposed OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Payment Status.

CMS proposes to accelerate the recoupment of $7.8 billion in payments redistributed under the 340B payment cuts that Supreme Court invalidated in 2022. Instead of the originally finalized 0.5% annual reduction over 16 years, CMS now seeks to impose a 2% annual reduction over just 6 years.

NRHA is deeply concerned that this accelerated timeline will effectively eliminate any net payment update for rural hospitals in CY 2025. We ask CMS not to finalize this change and retain the 16-year recoupment at 0.5%. Rural hospitals cannot sustain additional reductions layered on top of insufficient annual updates and proposed site neutral expansions. These facilities operate on the narrowest of margins, and a 2% reduction in Medicare reimbursement places many at heightened risk of closure.

Rural hospitals are uniquely situated to feel the accelerated payment cut more deeply than other hospitals because of their reliance on public payers, low volumes, and existing policies that reduce payment. In general, rural hospitals tend to have higher Medicare and Medicaid[9] volumes than urban hospitals. Thus, rural hospitals feel the effects of inadequate public payer reimbursement more acutely than urban hospitals. More reliance upon public payers coupled with lower volumes means that rural hospitals do not see enough revenue to cover the cost of providing many services. Ultimately, many rural hospitals lose money when serving Medicare beneficiaries. CMS has continually finalized annual hospital payment updates that do not account for the reality of inflation, workforce shortages, labor and supply chain pressures, and other costs. **A downward adjustment on top of low reimbursement will devastate many rural hospitals, therefore we ask CMS not to move forward with this change.**

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 are not sitting in reserve; they were expanded to meet urgent public health needs. The originally proposed 0.5% recoupment over 16 years, while difficult, offered a manageable glidepath and time to prepare. Quadrupling that rate to 2% with only a few months' notice is destabilizing.

NRHA urges the agency to revert to the originally finalized 16-year schedule. Moreover, given the significant strain rural providers will face from cuts to Medicaid expected under the One Big Beautiful Bill Act, CMS should consider reducing the recoupment further to 0.25% annually to

[8] *Id.*
[9] Timothy McBride, et al., *An Insurance Profile of Rural America: Chartbook*, RURAL POLICY RESEARCH INSTITUTE, UNIVERSITY OF IOWA COLLEGE OF PUBLIC HEALTH, Oct. 2022, 4, https://www.shepscenter.unc.edu/download/25553/; Levinson et al., *supra* note 5.

preserve rural health care access. This longer period allows for continued compliance with statutory requirements while avoiding disproportionate harm to rural hospitals that have already spent the redistributed funds during the COVID-19 pandemic to maintain operations and serve their communities.

C. Notice of Intent To Conduct Medicare OPPS Drugs Acquisition Cost Survey.

CMS intends to conduct a hospital acquisition cost survey for separately payable outpatient drugs in early 2026 as required by Social Security Act and reinforced by the President's recent Executive Order "Lowering Drug Prices by Once Again Putting America First." This survey is meant to generate a statistically significant estimate of the average hospital acquisition cost for each outpatient drug and will inform payment policy for outpatient drugs beginning with the CY 2027 OPPS rulemaking cycle.

NRHA acknowledges CMS' statutory authority to set Medicare reimbursement rates for outpatient drugs. However, **we are concerned about how the survey results will be used, in particular to potentially reintroduce large payment cuts for 340B drugs similar to the policy in place during CYs 2018 – 2022.** Many rural hospitals rely on 340B savings to finance uncompensated care, maintain service lines, furnish free medications, and provided services that would otherwise be untenable in rural areas.

If CMS decides to reduce outpatient drug reimbursement in CY 2027, **NRHA urges the agency to exempt all rural hospitals, including SCHs, MDHs, Low-Volume Hospitals (LVHs), Rural Emergency Hospitals (REHs) and small rural hospitals with 100 beds or less.** CMS exempted rural SCHs from the -22.5% payment policy for 340B drugs put in place in CY 2018, acknowledging that rural hospitals are in a more vulnerable financial position. This exemption must not only be maintained but extended to all rural hospitals paid under OPPS.

NRHA is also concerned with CMS' proposed treatment of non-responses. The suggestion that non-responding hospitals may be assumed to have lower acquisition costs or that their drug payments may be packaged into other services without clear justification could unfairly penalize rural hospitals already facing administrative capacity challenges. Rural hospitals must not be subject to punitive assumptions or alternative pricing methodologies that fail to reflect actual acquisition costs because they did not have the staff resources to respond to the survey. Such a survey will represent a significant burden for hospitals, especially smaller rural providers with limited administrative capacity. NRHA believes that CMS cannot estimate 340B acquisition costs for non-responding hospitals especially when these non-respondents are likely to be small rural hospitals with higher acquisition costs. Rural hospitals must not be penalized for lacking the staff or infrastructure to complete complex federal surveys. CMS should exclude non-responding hospitals from its survey dataset and not base payment policy on incomplete assumptions.

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

C. Proposed CY 2026 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. In the CY 2026 proposed rule, CMS maintains the current payment methodology for hospital-based providers furnishing IOP services. CMS proposes setting CY 2026 hospital-based IOP rates at $340.90 for 3 services per day and $424.60 for 4 or more services per day. NRHA supports the continued ability of rural hospitals and clinics to deliver IOP services, which are a critical component of the rural behavioral health continuum.

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

C. Proposed CY 2026 Changes to IPO List.

CMS proposes to eliminate the inpatient only (IPO) list over a three-year transition period, beginning with the removal of 285 predominantly musculoskeletal procedures in CY 2026. These procedures would be paid under OPPS when clinically appropriate, giving physicians more flexibility in choosing the site of care. CMS will continue to exempt procedures recently removed from the IPO list from certain two-midnight rule medical review activities until it determines that these services are commonly performed in outpatient settings.

NRHA appreciates CMS' commitment to aligning payment policy with clinical advancements. However, we urge caution regarding the proposed elimination of the IPO list and recommend that CMS not finalize its proposal to phase out the IPO only list. While advancements in technology have improved the safety of some outpatient procedures, there are remaining challenges regarding Medicare Advantage (MA) plans.

This proposal will have serious implications for all rural hospitals. In recent years, CMS has used the IPO list as a regulatory anchor when challenging certain MA plan practices, like improper claims denials and downcoding impatient stays to observation. Because MA plans are required to follow traditional Medicare coverage rules, the IPO list has served as an important tool in enforcing compliance. Its removal could open the door for MA plans to default to outpatient or observation-level payments more frequently, undermining physician judgement and disrupting hospital revenue streams. Rural hospitals are already dealing with MA plans increasingly denying inpatient stays and downgrading to observation stays against the clinical judgment of the treating physician.

NRHA is particularly concerned that MA insurers will increasingly rely on prior authorization on a claim-by-claim basis, further overriding physician decision-making and steering patients to specific sites of care. For rural hospitals already grappling with burdensome MA claim disputes, the elimination of the IPO list may become yet another major hurdle to securing appropriate reimbursement.

X. Nonrecurring Policy Changes.

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

In the CY 2023 OPPS final rule, CMS finalized a policy to exempt rural SCHs from its policy to pay for hospital outpatient clinic visits furnished at off-campus provider-based departments at the Medicare

Physician Fee Schedule (MPFS) rate, or 40% of the OPPS rate. CMS now proposes to continue this exemption. **NRHA urges CMS to consider exempting all small rural hospitals with 100 beds or less, MDHs, LVHs and REHs.** The same reasoning that led CMS to propose to exempt SCHs also applies to all small rural hospitals paid under the OPPS. Factors other than the payment differential can be attributed to the volume of services in provider-based clinics of rural hospitals.[10] Extending this site neutral exemption to MDHs and other small rural hospitals would ensure rural hospitals receive more adequate reimbursement and thus support access to care for beneficiaries in rural areas.

6. Impact of Unnecessary Increases in Volume on OPPS.

Rural hospitals and their off-campus PBDs provide essential services required for health care access in rural communities. **Current and proposed site neutral policies will significantly reduce payments to rural facilities and have the potential to exacerbate existing financial pressures on rural hospitals.** NRHA opposes any expansion of site neutral payment policies.

CMS proposes to apply Medicare Physician Fee Schedule (MPFS) equivalent rates to drug administration services provided at all off-campus provider-based departments (PBDs). This would amount to a 65% payment cut and reduce OPPS spending by $280 million in CY 2026, including $70 million in savings for Medicare beneficiaries.[11] While CMS exempts SCHs from this policy, **NRHA believes that small rural hospitals under 100 beds, as well as MDHs and LVHs, should be exempt from these drastic payment reductions.** These facilities deliver critical infusion and specialty services through off-campus PBDs and may be the only providers doing so in small rural communities. Between 2014 and 2023, 424 rural hospitals ceased chemotherapy services creating care deserts and threatening the stability of rural health safety net.[12] Payment reductions of this magnitude could result in service line closures, longer travel times for patients, and delayed care.

CMS maintains that because drug administration services are routinely and safely provided in physicians' offices there is no reason to pay for such services at the higher OPPS rate. NRHA disagrees with this argument as it does not recognize the role that hospitals and off-campus PBDs play in rural communities. **Rural hospitals rely more heavily upon off-campus PBDs to provide care in remote areas.** The more rural the county where a Medicare beneficiary resides, the more likely it is that they seek care in an off-campus PBD than a physician's office.[13] Additionally, Medicare accounts for a higher percentage of outpatient revenue in rural hospitals, making OPPS payments more important in rural hospitals compared to urban hospitals.[14] The financial burden imposed by site

[10] *Preserving rural health care: The impact of site neutral payments*, NATIONAL RURAL HEALTH ASSOCIATION, Nov. 2024, 1 https://www.ruralhealth.us/nationalruralhealth/media/documents/advocacy/nrha-site-neutral-policy-brief-2024.pdf.

[11] Emily Jane Cook, *CMS CY 2026 proposed rules: 340B in PFS and OPPS*, HEALTH & LIFE SCIENCES NEWS, July 23, 2025, https://www.healthlifesciencesnews.com/2025/07/cms-cy-2026-proposed-rules-340b-in-pfs-and-opps/.

[12] Topchik, *supra* note 3 at 7.

[13] American Hospital Association, *Analysis: Hospitals and health systems are critical to preserving access to care in rural communities*, Jan. 25, 2024, https://www.aha.org/2024-01-25-analysis-hospitals-and-health-systems-are-critical-preserving-access-care-rural-communities.

[14] Pranathi Sana & George H. Pink, *Medicare Covers a Lower Percentage of Outpatient Costs in Hospitals Located in Rural Areas*, NORTH CAROLINA RURAL HEALTH RESEARCH PROGRAM, CECIL G. SHEPS CENTER FOR HEALTH

neutral payments will force rural hospitals to make difficult operational decisions, such as reducing services, delay equipment purchases, or closing departments or entire facilities. Rural hospitals face unique challenges meeting requirements to provide 24/7 emergency care, comply with EMTALA, and meet stringent conditions of participation, which are not fully addressed by site-neutral payment rates. These challenges often result in higher costs per service compared to larger urban hospitals due to lower patient volumes, minimum staffing requirements, and standby capacity needs.

Additionally, physicians' offices are diminishing across rural America. As a result, rural communities are seeing a higher volume of patients at off-campus PBDs because of the growing challenges that rural physicians face. As it becomes increasingly difficult for independent rural physician practices to remain open, hospitals acquire these practices in an effort to retain access points for rural patients. Hospitals are two and a half times more likely to acquire rural physician practices than other entities.[15] This trend leads to more reliance upon off-campus HOPDs to ensure access to care in rural areas.

Should CMS move forward with this policy, **the agency must finalize its proposal to exempt rural SCHs and extend the same relief to MDHs, LVHs, REHs, and rural hospitals with 100 beds or less.** Extending site neutral policies without rural safeguards risks driving access challenges in these rural, underserved areas. These facilities serve as critical access points for rural beneficiaries to access outpatient care in geographically isolated areas, and applying site neutral payment to drug administration services could jeopardize their financial stability and reduce access to needed treatments like chemotherapy and infusions.

7. Request for Information: Expanding the Method to Control for Unnecessary Increases in the Volume of Covered OPD Services to On-Campus Clinic Visits.

Rural SCHs are excluded from the off-campus clinic visit policy. Should rural SCHs be excluded from any similar on-campus policy? Should any other type of hospital be excluded?

NRHA opposes any expansion of site neutral payments on hospitals located in rural areas. As CMS evaluates a potential expansion of volume controls to on-campus clinic visits, **we recommend a thorough rural impact assessment.** Should CMS move forward with site neutral payment for on-campus clinic visits, **NRHA urges the agency to carve out all small, rural hospitals**, including SCHs, MDHs, LVHs, and any rural hospitals with 100 beds or less. Rural hospitals often operate integrated outpatient clinics that serve high need populations. For example, dually eligible beneficiaries use hospital outpatient departments for care more than their non-dually eligible counterparts. Of this population utilizing outpatient departments, 72% have a complication or comorbidity compared to 64% that visit physicians' offices.[16] The ramifications extend beyond financial impacts and affect health care access in rural areas where reduced reimbursement can lead to service reductions or facility closures thereby worsening existing challenges such as longer travel distances to health care facilities and limited access to specialized services.

SERVICES RESEARCH, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL, Sept. 2021, 5 https://www.shepscenter.unc.edu/product/medicare-covers-a-lower-percentage-of-outpatient-costs-in-hospitals-located-in-rural-areas/.

[15] American Hospital Association, *supra* note 13.

[16] American Hospital Association, *supra* note 13.

This policy would be particularly damaging in rural communities, where on-campus provider-based clinics are often the only source of outpatient care. In urban areas, provider-based clinics may be distributed throughout a metropolitan region. In contrast, rural provider-based clinics are most often located directly on the hospital campus and are deeply integrated into the hospital's operations. These clinics exist not for profit, but to ensure that physicians and providers remain in the local area. If CMS reduces reimbursement for these services, many rural hospitals would be forced to close their clinics, leading to a significant loss in access to physician care.

CMS asserts that these visits could be safely provided in lower-cost settings such as physician offices. However, that assumption does not apply in rural communities where physician offices often do not exist. One practical method CMS could use to assess necessity is to determine whether the same specialty is available elsewhere in the community. If it is not, the hospital-based clinic is clearly providing necessary and irreplaceable care.

What would be the impact on providers of such a policy? Would any category of hospital be impacted more than others, for example, those in rural areas? Would such a policy result in lower on-campus OPD volume for clinic visits?

As discussed above, Medicare accounts for a higher percentage of outpatient revenue in rural hospitals, making OPPS payments more important in rural hospitals compared to urban hospitals.[17] The financial burden imposed by expanded site neutral payments will force rural hospitals to make difficult operational decisions, such as reducing services, delaying equipment purchases, or closing departments or entire facilities. These decisions ultimately impede rural beneficiaries' access to care. Site neutral payment would add to the challenges and cuts that rural hospitals are already facing – inadequate Medicare reimbursement, CMS' proposed accelerated -2% recoupment, pending cuts to Medicaid, dwindling 340B savings, uncertain extensions of the MDH and LVH designations, and proposed site neutral expansions. Holistically, these policies all threaten the stability of the rural health infrastructure and ultimately rural beneficiary access to care.

C. Virtual Direct Supervision of Cardiac Rehabilitation (CR), Intensive Cardiac Rehabilitation (ICR), Pulmonary Rehabilitation (PR) Services and Diagnostic Services Furnished to Hospital Outpatients.

NRHA supports CMS' proposal to make permanent the option for virtual direct supervision of CR, ICR, PR, and most diagnostic services furnished to hospital outpatients via two-way, real-time audio-video technology. Rural providers continue to face longstanding workforce shortages and geographic barriers that make in-person supervision challenging. Permanent flexibility for virtual supervision will help ease workforce shortages and make workflows more efficient. NRHA appreciates CMS' recognition that supervising practitioners must retain discretion in determining the appropriate supervision modality.

[17] Sana & Pink, *supra* note 14.

8. All-Inclusive Rate (AIR) Add-On Payment for High-Cost Drugs Provided by Indian Health Service and Tribal Facilities.

NRHA supports CMS' proposal to pay Indian Health Service (IHS) and tribal hospitals separately for high-cost outpatient drugs. We agree with CMS' conclusion that paying separately for these drugs will enable IHS and tribal hospitals to continue to or begin to provide much-needed specialty care.

XVIII. Overall Hospital Quality Star Reporting.

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

NRHA appreciates CMS' efforts to elevate patient safety within the star rating system; however, we urge CMS to proceed cautiously with the proposed changes, particularly the blanket 1-star reduction (Stage 2), given its potential to disproportionately affect small, rural hospitals with limited Safety of Care reporting volumes. Rural hospitals, especially CAHs, small PPS hospitals, MDHs, and SCHs, often face structural and resource limitations that make meeting reporting thresholds for these Safety of Care measures more difficult. Many of these facilities contend with low patient volumes, staffing shortages, and narrower service lines, all of which impact their ability to capture and report sufficient data across all measure groups.

NRHA is particularly concerned that the proposed changes could exacerbate existing disparities in how rural hospital quality is represented to the public. Beneficiaries and other users may misinterpret what star ratings mean or what the absence of star ratings indicates about the quality of care provided at rural hospitals.[18] Even among hospitals that do receive a rating, a methodology that fails to account for rural-specific limitations in measure reporting may inaccurately signal lower quality and penalize facilities serving high-need, underserved populations. **While CMS's own simulation suggests that large, urban, non-critical access hospitals would be more commonly affected by the proposed changes, the methodology still risks penalizing hospitals with fundamentally different operating realities.** Applying a uniform ratings adjustment without stratification or appropriate adjustment for hospital size, geography, and service availability could misrepresent quality performance in rural communities and undermine hospital sustainability. NRHA urges CMS to consider a more tailored approach, such as stratifying ratings or incorporating rural-specific risk adjustment, to avoid unfairly disadvantaging low-volume providers.

Additionally, Medicare star ratings are problematic for CAHs. Some CAHs do not receive star ratings or star ratings are skewed because of structural factors that favor urban, high-volume hospitals. Star ratings for hospitals range from 1 to 5, with 5 being the best rating. However, many CAHs tend to have lower volumes and do not have enough patient surveys to receive a star rating.[19] Changing patterns of healthcare delivery has led to insurance companies only approving observation stays, not inpatient stays, which further drives down rural inpatient volumes. NRHA suggests that CAHs and other small rural hospitals have a required survey volume that is proportional to their volume of patients.

[18] Per Ostmo, *Quality Star Ratings: Hospitals, Skilled Nursing Facilities, and Home Health Agencies*, RURAL HEALTH RESEARCH GATEWAY, March 2024, https://www.ruralhealthresearch.org/assets/5643-26187/quality-star-ratings-recap.pdf.

[19] The required inpatient survey volume for all hospitals – from CAHs to urban tertiary centers – is 100.

XV. Hospital Outpatient Quality Reporting (OQR) Program.

B. Proposed Changes to the Hospital OQR Program Measure Set.

NRHA appreciates CMS's effort to explore the integration of well-being and nutrition into future quality measurement. These domains are especially relevant to rural hospitals, which serve older, higher-needs populations and often act as the sole source of preventive care in their communities.

That said, NRHA urges CMS to approach development cautiously and collaboratively. New measures in this area must be feasible for hospitals with limited staffing, health IT capacity, and behavioral health or dietetic support. NRHA recommends that any well-being or nutrition-related measures begin as attestation-based, non-punitive, and supported by technical assistance tailored to rural facilities. CMS should align future measurement efforts with existing federal programs and screeners, such as the Malnutrition Care Score or USDA nutrition support services, to reduce redundancy and promote integration.

NRHA encourages CMS to consider the relationship between these quality measure concepts under consideration and the two measures proposed to be removed related to screening and screening positive for social determinants of health (SDOH) in the Hospital OQR Program.

As stated in the proposed rule, the Hospital OQR program is a "pay-for reporting program intended to ensure transparency and quality of care furnished at hospital outpatient departments (HOPDs), improve the quality of care provided to Medicare beneficiaries, and facilitate public transparency." Future measures that incorporate well-being and nutrition into the OQR Program will likely mean leveraging community support services or providing resources to assist patients in improving these factors, making the capturing information on quality measures of well-being and nutrition an important clinical tool.

For example, poor nutrition may be related to food insecurity, which is one of the health-related social needs included in the SDOH quality measures CMS is proposing to remove. Food insecurity is defined as limited or uncertain access to adequate quality and quantity of food at the household level. It is associated with diminished mental and physical health and increased risk for chronic conditions. Food insecurity is also associated with high-cost healthcare utilization including emergency department visits and hospitalizations. NRHA emphasizes that in rural areas, patients face heightened barriers to nutritional security, such as geographic isolation, fewer food retailers (particularly those with fresh and nutritious foods), limited access to transportation, and underfunded social services. Rural hospitals and CAHs often serve as both health care providers and de facto community hubs, meaning they are uniquely positioned but not always adequately resourced to screen for and respond to food insecurity and related social needs. Without a mechanism to support rural hospitals in collecting information related to connecting patients to services that improve nutrition and well-being, such quality measures risk becoming an administrative burden rather than a lever for improved patient outcomes.

Therefore, NRHA asks CMS to ensure that any future measures of nutritional status are directly tied to screening for food insecurity and that data captured under the Hospital OQR Program is actionable, particularly for rural providers. These measures should not operate and account for the capacity constraints and geographic challenges rural hospitals face.

We encourage CMS to consider other quality measures that may be linked in this way and preserve these mutually beneficial measures within these programs.

XVI. Rural Emergency Hospital Quality Reporting (REHQR) Program.

NRHA supports CMS' proposal to adopt the Emergency Care Access and Timeliness eCQM beginning with the CY 2027 reporting period/CY 2029 program determination. We agree that this measure appropriately addresses the growing challenges of emergency department occupancy and boarding, which directly affect patient safety and timeliness of care.

XIX. Updates to Requirements for Hospitals To Make Public a List of Their Standard Charges

B. Proposal To Modify the Requirements for Making Public Hospital Standard Charges at 45 CFR 180.50.

NRHA has significant concerns about rural hospitals' capacity to meet hospital price transparency (HPT) requirements. We have consistently expressed[20] that rural hospitals will struggle to dedicate staff and resources to complying with the HPT regulations and potential civil monetary penalties.

NRHA opposes further additions to HPT regulations that will be overly burdensome for rural hospitals, including the following:

- Beginning January 1, 2026, reporting and encoding in the machine-readable file (MRF) the 10th percentile and 90th percentile allowed amounts.
- Beginning January 1, 2026, reporting and encoding in the MRF the median allowed amount rather than estimated allowed amount if the payer-specific negotiated charge is based on a percentage or algorithm.
- Expanding hospital MRF attestation requirements.
- Requiring hospitals to encode new hospital information in their MRF including the name of the hospital CEO, president, or other official overseeing the encoding of true, accurate, and complete data and the hospital NPI.

We disagree that now is the time to be more prescriptive in data formatting requirements, particularly for rural hospitals that are continually struggling to keep up with HPT regulations. Alternatively, if CMS moves forward with the new template and data elements, NRHA urges CMS to extend the grace period from 60 days to 120 days after the effective date of this rule for small rural hospitals and CAHs. Nothing in the HPT statute prohibits this grace period and rural hospitals would benefit from additional time to comply.

[20] https://www.ruralhealth.us/getmedia/55fe50f1-ecdf-42fa-84c6-8d45b171d11f/NRHA-Comments-on-Requirements-Related-to-Surprise-Billing-(Part-I).aspx and https://www.ruralhealth.us/getmedia/5765f1a7-e650-4d14-901c-0e4d8842b8a1/NRHA-Comments-on-Medicare-CY-2022-Hospital-Outpatient-Prospective-Payment-and-Ambulatory-Surgical-Center-Payment-Systems.aspx

XX. Proposed Market-Based Medicare Severity-Diagnosis Related Groups (MS-DRG) Relative Weight Data Collection and Change in Methodology for Calculating MS-DRG Relative Weights Under the Inpatient Prospective Payment System.

CMS proposes to require hospitals to collect on the Medicare cost report the median payer-specific negotiated charge that the hospital has negotiated with all of its Medicare Advantage organizations (MAOs), by MS–DRG. This would go into effect for hospitals' cost reporting periods ending on or after January 1, 2026. This data would be used to calculate Inpatient Prospective Payment System (IPPS) MS-DRG relative weights beginning in FY 2029.

NRHA strongly opposes this proposal and has two main concerns with this policy. First, this would add significant burden on rural hospitals. Rural hospitals will be required to collect and assemble additional data to add to their Medicare cost report. Rural hospitals are required to report median payer-specific negotiated charge for HPT requirements; however, they would have to take additional steps to calculate and add this on the cost report, especially if it is not disclosed as a dollar amount for HPT purposes. CMS also proposes to require hospitals to report this data by MS-DRG, which adds a new level of complexity and administrative effort for facilities with limited technical staff.

CMS maintains that since HPT requirements have gone into effect, hospitals have become more familiar and experienced with disclosing this data on the MRF, so the burden of including this information on the cost report is low. NRHA disagrees with this assessment as it does not consider the circumstances of rural hospitals. Rural hospitals already face significant compliance challenges under the HPT rule. A 2024 OIG audit found that 46% of all hospitals failed to post required standard charge data, reflecting widespread difficulty even with existing mandates.[21] Rural hospitals, which allocate 18 percent more of their total expenses to administrative salaries compared to urban peers, are particularly strained.[22] Adding additional layers of complexity, such as new MRF reporting elements, would worsen this burden. **NRHA believes that not finalizing this proposal will better align with the Administration's deregulatory focus.** We also emphasize that rural hospitals often lack the necessary software or staff to compile median payer-specific negotiated charges by MS-DRG, especially if the data is not readily available or easily extractable. NRHA asks CMS to consider exempting rural hospitals from this data collection.

We also do not agree with CMS' assessment that there is a need to move away from reliance on the hospital chargemaster and instead develop market-based approaches to payment to calculate IPPS MS-DRG relative weights. CMS states that the rates that hospitals negotiate with MAOs provide greater insight into the actual resource use of a hospital. For rural hospitals that have little bargaining power compared to MAOs, this is false. One issue that NRHA regularly hears from its members is that they lack the negotiating power to contract with MAO plans to receive sustainable reimbursement rates. Particularly as MA enrollment continues to increase compared to Traditional

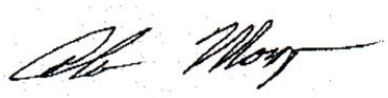
[21] OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, *Not All Selected Hospitals Complied With The Hospital Price Transparency Rule* (Nov. 2024) https://oig.hhs.gov/documents/audit/10042/A-07-22-06108.pdf.
[22] Lauree Handlon, et al., *Trends in hospital administrative costs: urban-rural disparities, barriers, and reduction strategies*, HEALTH AFFAIRS SCHOLAR, Aug. 8, 2025, https://doi.org/10.1093/haschl/qxaf149.

Medicare, rural hospitals are hamstrung between negotiating potentially unfavorable contracts or not providing in-network coverage for growing portion of their patient population. Most rural hospitals will choose the former so that beneficiaries have access to care in their community, even if it means harm to the rural hospital. NRHA contends that CMS is conflating market price with cost by assuming that rates negotiated with MAOs actually represent rural hospital resource costs.

Last, NRHA is extremely concerned that the new methodology using this data will underpay rural hospitals. As it stands, rural PPS hospitals are struggling to stay afloat given inadequate Medicare payment rates. We do not support overhauling the calculation of MS-DRG relative weights to be based upon so-called market-based methodology.

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 Government Affairs and Policy Director Alexa McKinley Abel at amckinley@ruralhealth.us.

Sincerely,



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National Rural Health Association