

March 30, 2026

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

**RE: CMS-1516-ANPRM; Medicare Program; Ensuring Safety Through Domestic Security With Made in America Personal Protective Equipment (PPE) and Essential Medicine Procurement by Medicare Participating Hospitals**

***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) advanced notice of proposed rulemaking to ensure a more resilient supply chain for American-made personal protective equipment (PPE) and essential medicines.

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, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

### **III. Potential Establishment of a Publicly Reported Hospital Designation Reflecting Medicare Participating Hospitals' Commitment To Procuring Domestic PPE and Essential Medicines.**

NRHA's support for establishing a new, publicly reported hospital designation depends upon the benefit compared to the administrative burden and resources needed to achieve such designation for small rural hospitals. In general, NRHA may support a designation as an incentive to procure domestically-made PPE and essential medicines if CMS can also incentivize hospitals to seek the designation.

NRHA cautions CMS against reporting measures and hospital designations that can inadvertently exclude rural hospitals from the benefits of such designations. Similar to the birthing friendly designation finalized in 2022,<sup>1</sup> various factors, like staff shortages, may prevent a rural hospital from positively attesting to the reporting measures and subsequently receiving the hospital designation.

NRHA offers responses to CMS' specific questions below:

- *For administering the designation, what are potentially useful alternatives to self-attestation?*

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<sup>1</sup> Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals, 87 Fed. Reg. 48,780, 49,282 (Aug. 10, 2022) (codified at 42 C.F.R. pts. 412, 413, 482, 485, and 495).

While attestation-based measures are usually less onerous than others, significant administrative requirements around assessing, gathering and providing proof of purchase of PPE and medicines from domestic manufacturers may be challenging for small rural providers. Today, more than 40% of rural hospitals are operating at a loss leading to 417 facilities being vulnerable to closure.<sup>2</sup> Typically, rural hospitals do not have a robust dedicated administrative staff. If a hospital does, it is a small team that handles all administrative tasks.

CMS could consider allowing self-attestation on the cost report without providing upfront proof of domestic purchases. Alternatively, CMS could ask for proof from hospitals every other year so that the burden is spread over time and rural hospitals have advanced notice of what is needed.

- *Should such a policy be phased in overtime to increase hospital adoption and prevent shortages, and if so, how? For example, should such a policy be phased in such that at least 25 percent, 50 percent, and eventually 75 percent of a hospital's total procurement across contracts for PPE and essential medicine is domestically manufactured?*

Yes, NRHA supports phasing this policy over time. Rural hospitals would be more likely to qualify for the designation if they are able to incrementally meet domestically manufactured thresholds rather than an all or nothing approach when it is first implemented. This approach would give rural hospitals time to transition towards more domestic contracts for PPE and essential medicines if needed.

- *When and how should we provide flexibilities under such a policy in the event of supply chain disruptions like natural disasters and demand surges?*

CMS should consider providing flexibility during state and federal public health emergencies issued by the Department of Health and Human Services or state equivalent agencies. CMS should also provide flexibility during major disaster declarations from the Federal Emergency Management Agency (FEMA). As we have seen through major natural disasters like Hurricane Helene, rural hospitals and other healthcare operations can be severely disrupted and normal procurement methods may not be possible.

#### **IV. Potential Separate Medicare Payment To “Secure American Medical Supplies” Friendly Hospitals.**

CMS puts forth a potential separate payment for hospitals that achieve the Secure American Medical Supplies designation. CMS proposes to derive separate payment from cost report data on the number of days that the hospital treated Medicare fee-for-service patients, reasonable assumptions on PPE use per hospital day, and additional domestic PPE costs. For essential medicines, CMS proposes to derive the payment using cost report data on Medicare's Inpatient Prospective Payment System (IPPS) share of the hospital's total drug costs and reasonable assumptions on what percentage of those costs are for essential medicines.

NRHA supports providing separate payment to help small, rural hospitals secure medical supplies, and prescription drugs. We offer the following feedback to ensure that rural hospitals are adequately supported through this payment mechanism.

- *What additional costs or burdens would be incurred by a hospital to achieve this designation? How would facilities cover this cost? What resources could CMS provide to help hospitals address intangible barriers to earning the designation?*

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<sup>2</sup> <https://www.chartis.com/insights/2026-rural-health-state-state>

Generally, the biggest cost associated with potential designation is diversion of existing staff time to activities. Again, rural hospitals do not have a robust administrative staff and may not be financially able to hire additional staff. CMS could consider building in costs for staff time spent on compliance activities into the separate payment. In addition to building additional domestic PPE costs into the payment equation, CMS could add another flat amount to cover staff costs associated with achieving the designation. The same could be done to calculate payment for essential medicines.

- *For each type of PPE, would Medicare FFS inpatient days be an appropriate basis for deriving the Medicare IPPS utilization of the PPE?*

NRHA believes that Medicare FFS inpatient days would be the best approach to derive Medicare IPPS PPE utilization.

- *For PPE, in addition to separate payment for the higher inpatient hospital costs, should Medicare also consider making separate payment for the higher outpatient hospital costs?*

Yes, a separate payment should be made for higher outpatient costs. Approximately 75% of small rural hospital revenue comes from outpatient services, comprising the majority of their service delivery.<sup>3</sup> Any additional costs for domestically made PPE borne by rural hospitals in the outpatient setting should be recognized through this payment mechanism as well.

- *Would it be appropriate to expand a potential payment policy beyond IPPS and OPSS hospitals to other entities that receive Medicare payments?*

NRHA urges CMS to expand this payment policy to critical access hospitals (CAHs). CAHs are by definition small, rural hospitals – they must have 25 beds or less and generally be located more than 35 miles from the next nearest hospital. These types of small rural hospitals are the hospitals that would benefit most from a payment incentive to procure domestically made PPE and essential medicines.

CAHs are not paid under the traditional prospective payment system and would be exempt from CMS' proposed payment as written in the ANPRM. CAHs would need a special separate payment from CMS outside of IPPS or OPSS. CAHs are required to submit cost reports like PPS hospitals and could self-attest on their cost report and receive the incentive payment based on Medicare patient days. CAHs are paid 101% of reasonable costs for inpatient and outpatient care, including supplies, by Medicare. CMS must incorporate this separate payment amount into CAH reimbursement to ensure they receive the same benefits for purchasing domestic supplies as other hospitals paid under the PPS.

NRHA also asks that CMS expand payment to rural health clinics (RHCs), which are paid by Medicare on a separate payment system called an all-inclusive rate (AIR). RHCs are paid their AIR, or a bundled payment, per visit for qualified primary care and preventive health services. RHCs can receive payments from Medicare for certain services outside of the AIR. For example, RHCs are paid outside of their AIR for advanced primary care management services under the Physician Fee Schedule.<sup>4</sup> CMS should explore options for add-on payments for RHCs that would cover the additional costs associated with procuring domestic PPE and essential medicines, likely in the form of a separate Medicare payment outside of the AIR.

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<sup>3</sup> <https://www.shepscenter.unc.edu/product/trends-in-revenue-sources-among-rural-hospitals/>

<sup>4</sup> Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies, 89 Fed. Reg. 97,710, 98,012 (Dec. 9, 2024)

## V. Hospital IQR Program Measure.

NRHA does not support a new structural measure in the Hospital Inpatient Quality Reporting Program (IQR). First, ANRPM appears to imply that this measure would be in addition to earning the Secure American Medical Supplies designation, which would already require hospitals to self-attest to procuring domestic made supplies. As such, adding an attestation to the Hospital IQR would seemingly be duplicative. Second, there seems to be a misalignment as a measure on the Hospital IQR set would be required whereas achieving the designation would be optional. In general, NRHA does not support adding additional obligations onto rural hospitals unless the benefit clearly outweighs the burden and in the context of the IQR, we do not believe that is the case. NRHA asks that CMS instead move forward with the Secure American Medical Supplies designation and a low-burden self-attestation process through the Medicare cost report instead of a mandatory measure in the Hospital IQR.

- *Would a structural attestation measure in the Hospital IQR Program be an appropriate way to bring transparency as to hospital procurement of domestically manufactured items and incentivize hospitals to prioritize resources for increasing procurement through domestic supply?*

NRHA urges CMS to incentivize hospitals to procure domestic PPE and essential medicines by earning the Secure American Medical Supplies designation rather than through a structural attestation measure. This option would provide more flexibility for rural hospitals, such as through a phase-in of the policy as described above. Additionally, the Hospital IQR is a pay-for-reporting program whereas the separate incentive payment tied to earning the designation would be better tailored to cover the additional costs associated with purchasing domestic supplies.

- *What would be the least burdensome effective method to audit or validate hospitals' attestation responses, as feasible?*

CMS should not require upfront proof of domestic procurement but rather perform regularly scheduled audits that are announced in advance. NRHA suggests that CMS audit hospitals every other year for proof and ensure direct communication with individual rural hospitals about when they can expect to be audited.

Thank you for the chance to offer feedback on this advanced notice of proposed rulemaking and for your consideration of our comments. We very much look forward to continuing our work together to ensure our mutual goal of improving quality and access to care for rural residents. If you would like additional information, please contact Alexa McKinley Abel at [amckinley@ruralhealth.us](mailto:amckinley@ruralhealth.us).

Sincerely,



Alan Morgan  
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National Rural Health Association