National Rural Health Association

June 10, 2025

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

RE: CMS-1833-P; Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals, Long-Term Care Hospital Prospective Payment System Policy Changes, and Fiscal Year 2026 Rates; Requirements for Quality Programs; and Other Policy Changes.

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 Inpatient Prospective Payment System (IPPS) for Acute Care Hospitals for fiscal year (FY) 2026. We appreciate CMS' continued commitment to the needs of the more than 60 million Americans that reside in rural areas, and we look forward to our continued collaboration to improve health care access throughout rural America.

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

II. Proposed Changes to Medicare Severity Diagnosis-Related Group (MS-DRG).

NRHA has concerns about the impact of annual MS-DRG changes, including changes to the relative weights that occur as part of recalibration, and the associated budget neutrality adjustment CMS applies on rural hospitals. These methodological changes, while intended to be budget neutral in aggregate, result in systematic and disproportionate disadvantages for rural hospitals.

Historically, from FY 2014 through FY 2021, CMS's impact tables revealed a consistent trend: rural hospitals experienced greater negative impacts from MS-DRG recalibrations than their urban counterparts. While this trend moderated slightly in FY 2022 and FY 2023, the FY 2026 proposed rule once again shows rural hospitals absorbing more significant payment cuts. Specifically, the FY 2026 IPPS impact table shows a 0.0% impact for urban hospitals, compared to a –0.5% impact for all rural hospitals and a –0.6% impact for sole community hospitals (SCHs).

The FY 2026 proposed rule demonstrates that rural hospitals continue to lose ground on DRG payments due to structural issues within the recalibration and budget neutrality processes. To protect the viability of rural hospitals, it is essential that CMS examine how its current rate-setting methodology can contribute to disproportionate disadvantages to rural hospitals. Should this examination reveal such systematic, negative impacts on rural hospitals, CMS should consider making payment methodology adjustments.

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III. Proposed Changes to the Hospital Wage Index for Acute Care Hospitals.

F. Wage Index Adjustments: Rural Floor, Imputed Floor, State Frontier Floor, Out-Migration Adjustment, Low Wage Index, and Cap on Wage Index Decrease Policies.

5. Discontinuation of the Low Wage Index Hospital Policy and Budget Neutrality Adjustment.

The low wage index policy is slated for removal following a D.C. Court of Appeals ruling. **NRHA is concerned about the negative impacts to the 323 rural hospitals that have benefited from the policy. NRHA supports CMS' proposal for transitional payments to hospitals experiencing a drop greater than 9.75% compared to FY 2024**.

NRHA strongly opposes the full discontinuation of the low wage index hospital policy and its associated budget neutrality adjustment. We ask that CMS work alongside its colleagues in Congress to codify the low wage index policy in statute. The policy, initially adopted in FY 2020, provided critical support to hospitals in the bottom quartile of wage index values, allowing them to better attract and retain staff by offering competitive wages without waiting years for those increases to be reflected in reimbursement rates.

The policy had value for rural hospitals, which continue to face systemic workforce shortages and suppressed wage scales. Its removal, without a long-term replacement, risks widening disparities between low-and high-wage regions and undermines financial stability for already vulnerable providers. NRHA urges CMS to work with its partners in Congress to restore or replace the low wage index protections in a manner that complies with the court's decision while preserving vital support for low-wage rural facilities.

7. Proposed Transition for the Discontinuation of the Low Wage Index Hospital Policy.

CMS's proposed transitional payment would apply to hospitals whose FY 2026 wage index would decrease by more than 9.75% compared to their FY 2024 wage index. The transitional payment exception for FY 2026 for such hospitals would be equal to the additional FY 2026 amount the hospital would be paid under the IPPS if its FY 2026 wage index were equal to 90.25% of its FY 2024 wage index. While NRHA appreciates CMS's effort to mitigate the steepest cuts associated with the discontinuation of the low wage index hospital policy, **NRHA is concerned that the proposed transition is too narrow in both scope and duration, affecting only an estimated 52 hospitals, most of which are not rural** in FY 2026.

Rural hospitals previously benefitting from the low wage index policy often serve as the sole health care provider in their communities, yet face persistent barriers to recruitment and retention due to suppressed reimbursement and noncompetitive wage structures. The removal of this policy, even with a transitional payment, may accelerate financial distress for hospitals that are already operating with thin or negative margins. While CMS's application of a temporary transitional payment with budget neutrality reflects consistency with prior practice, it does not resolve the underlying structural wage index inequities that the low wage index policy was designed to address. The proposed policy does not account for the cumulative effect of two consecutive years of wage index reductions on hospitals in persistently low-wage areas, especially in rural regions where there are few levers to increase wage competitiveness.

NRHA recommends that CMS expand the transitional payment exception to include hospitals experiencing a cumulative decrease of 7.5% or greater from FY 2024 to FY 2026, not just those

exceeding the 9.75% reduction threshold. In addition, NRHA urges CMS to extend this transition for **at least two additional fiscal years** to allow affected hospitals more time to adapt their financial planning and workforce strategies to the change.

Finally, NRHA reiterates the call for a **permanent, statutory solution to rural wage index suppression**, either through targeted wage index floor adjustments or a new rural hospital labor payment adjustment that accounts for persistent recruitment challenges in underserved areas. While NRHA respects the court's decision in *Bridgeport Hospital v. Becerra*, rural hospitals must not be left behind in the shift to prospective payment accuracy. Transition policies, while helpful, are not a substitute for durable rural wage index reform.

V. Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2026.

E. Uncompensated Care Payments.

In this rule, CMS estimates that total Medicare DSH payments for FY 2026 will amount to approximately $15.682 billion. Of this, roughly $3.92 billion (25 percent) will be allocated through empirically justified DSH payments, while the remaining 75 percent, approximately $11.761 billion, will be distributed as uncompensated care payments. NRHA thanks CMS for this update to uncompensated care payments.

VI. Other Proposed Decisions and Changes to the IPPS for Operating Costs.

B. Proposed Changes in the Inpatient Hospital Update for FY 2026 (§ 412.64(d)).

1. Proposed FY 2026 Inpatient Hospital Update.

NRHA thanks CMS for the proposed 2.4% payment update for hospitals. However, NRHA finds this update is inadequate given inflation, workforce shortages, and labor and supply chain cost pressures that rural hospitals continue to face. Since 2010, almost 190 rural hospitals have closed or ceased inpatient services[1] and another 432 additional hospitals are vulnerable to closure.[2] Further, nearly 50% of rural hospitals are operating with negative margins and the median operating margin for rural hospitals is 1%.[3] Losing a hospital is devastating to a rural community as beneficiaries lose a local point of access to care.

NRHA recommends that CMS consider how it can use its regulatory authority to boost payments to rural hospitals. Given the historical discrepancies between the projected and actual market basket indexes, hospitals need an adjustment to account for past inadequate payments. Section 1886(d)(5)(I)(i) of the Social Security Act gives the Secretary the authority to make any additional exceptions or adjustments to payments under subsection (d) as deemed necessary.[4] This would

[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., *2025 rural health state of the state*, Chartis Center for Rural Health (2025), 4, https://www.chartis.com/sites/default/files/documents/CCRH%20WP%20-%202025%20Rural%20health%20state%20of%20the%20state_021125.pdf.
[3] *Id.* at 2.
[4] 42 U.S.C. § 1395ww(d)(5)(I)(i) (2018) ("The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate").

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include the IPPS standardized payment amounts. **NRHA urges CMS to consider updating the final payment rate to reflect the difference between prior years' actual and forecasted market basket increases through its exceptions and adjustments authority.** Congress granted the Secretary broad authority through this provision and NRHA maintains that the current financial pressures that hospitals are experiencing warrant use of this provision. Swift legislative and regulatory action are needed to protect rural hospitals and mitigate the rural hospital closure crisis.

Alternatively, CMS finalized a separate IPPS payment to establish and maintain a buffer stock of essential drugs in this proposed rule. In the past, CMS paid hospitals for their costs associated with procuring NIOSH-approved N95 respirators during the COVID-19 pandemic. NRHA believes that CMS can similarly use this authority to add on payments to rural hospitals that are struggling to operate in the face of inadequate Medicare reimbursement.

D. Proposed Payment Adjustment for Low-Volume Hospitals (§ 412.101).

NRHA appreciates the temporary legislative extensions that have preserved the enhanced low-volume hospital payment adjustment through September 30, 2025. However, NRHA is deeply concerned that, absent Congressional action, the criteria will revert in FY 2026 to a 25-mile distance and fewer than 200 discharge thresholds, standards that are far too restrictive to meaningfully support the rural hospitals that rely on this adjustment. The loss of this support would disproportionately affect small rural hospitals already operating on thin margins, particularly those serving geographically isolated communities. NRHA urges CMS to work with Congress to permanently extend or modernize the low-volume adjustment thresholds to reflect current rural care realities, including the persistent workforce shortages, declining inpatient volumes, and increased per-discharge costs facing rural providers.

In the event that the low-volume payment adjustment temporarily lapse due to congressional inaction, NRHA urges CMS to retroactively reinstate payments as soon as possible. In the past, CMS has instituted retroactive payments to affected hospitals once Congress reauthorized the programs, but these restorations have seen delays that cause cash flow issues to rural hospitals.

E. Proposed Changes in the Medicare-Dependent, Small Rural Hospital (MDH) Program (§ 412.108).

NRHA strongly supports the MDH program and appreciates CMS's proposal to make the necessary regulatory updates to reflect its legislative extension through September 30, 2025. MDHs provide essential inpatient care in rural communities that are heavily reliant on Medicare and often lack other options for hospital services. The MDH program has served as a critical financial lifeline for many of these facilities, helping to ensure continuity of care and local access in the face of low patient volumes and high per-discharge costs.

NRHA is deeply concerned that, absent further Congressional action, the MDH program will expire on October 1, 2025. Such a lapse would result in a sudden shift to the federal rate for eligible hospitals, threatening their financial stability and potentially accelerating rural hospital closures. NRHA calls on CMS to work with Congress to pursue a permanent authorization of the MDH program or secure a long-term extension that offers certainty to rural providers and the communities they serve. NRHA also recommends that CMS provide technical assistance to MDHs seeking to transition to SCH status should the program expire without legislative remedy.

In the event that the MDH designation temporarily lapse due to congressional inaction, NRHA urges CMS to retroactively reinstate payments as soon as possible. In the past, CMS has instituted retroactive payments to affected hospitals once Congress reauthorized the programs, but these restorations have seen delays that cause cash flow issues to rural hospitals.

F. Payment for Indirect and Direct Graduate Medical Education Costs (§§ 412.105 and 413.75 Through 413.83)

SCHs and MDHs are paid at the greater of the federal rate (IPPS rate) or a hospital-specific rate (HSR). Those paid under the hospital-specific rate do not currently receive indirect medical education (IME) payments. SCHs and MDHs represent almost 80% of rural hospitals eligible to establish training programs but are disincentivized under the current GME payment framework.[5] Equitable IME payments will help SCHs and MDHs currently training residents and those that are interested in starting a residency program. NRHA believes that CMS retains the authority to ensure that SCHs and MDHs paid under their HSR receive IME, which would constitute a major step towards encouraging more physician training in rural areas.

X. Proposed Quality Data Reporting Requirements for Specific Providers.

C. Requirements for and Changes to the Hospital Inpatient Quality Reporting (IQR) Program.

2a. Measure Concepts Under Consideration for Future Years in the Hospital IQR Program – Request for Information: Well-being and Nutrition

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-need 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.

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

As stated in the proposed rule, the Hospital IQR program is a "pay-for-reporting program intended to measure the quality of hospital inpatient services, improve the quality of care provided to Medicare beneficiaries, and facilitate public transparency." Future measures that incorporate well-being and nutrition into the IQR Program will likely mean leveraging community support services or providing resources to assist patients in improving well-being or nutrition. Otherwise, capturing information

[5] Alliance for Rural Hospital Access, *SCHs, MDHs Can Improve Rural Physician Shortages*, https://ruralhospitalaccess.org/wp-content/uploads/2023/05/PositionPaper_118thCongressTrainingPrograms_Sept2023Update.pdf.

on quality measures of well-being and nutrition is not productive in improving the quality of services or care provided.

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 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 IQR 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. NRHA offers the same rationale for the similar proposal of quality measure concepts under consideration for the Long-Term Care Hospital Quality Reporting Program (LTCH QRP) in this proposed rule.

3. Proposed Refinements to Current Measures in the Hospital IQR Program Measure Set.

a. Hospital 30-Day, All-Cause Risk-Standardized Mortality Rate Following Stroke Hospitalization (MORT-30-STK).

NRHA supports CMS's proposal to include Medicare Advantage (MA) beneficiaries in the measure cohort. This change reflects the current Medicare landscape, where MA enrollment now represents nearly half of all rural beneficiaries[6], and it will improve the representativeness and reliability of measure scores. NRHA also supports shortening the reporting period from three years to two, which will allow performance results to better reflect recent quality improvement efforts and emerging trends.

b. Hospital-Level, Risk-Standardized Complication Rate Following Elective Primary Total Hip and/or Total Knee Arthroplasty (RSCR-THA/TKA).

NRHA supports the proposed inclusion of MA beneficiaries in the RSCR-THA/TKA measure. Including this patient population is necessary to ensure that performance metrics reflect the full Medicare landscape and to improve the reliability of scores, especially in low-volume facilities.

[6] Fred Ullrich & Keith Mueller, *Medicare Advantage Enrollment Update 2024*, RUPRI CENTER FOR RURAL HEALTH POLICY ANALYSIS, University of Iowa, 4, Jan. 2025, https://rupri.public-health.uiowa.edu/publications/policybriefs/2025/2024%20MA%20Enrollment%20Update.pdf.

4. Proposed Removals in the Hospital IQR Program Measure Set.

NRHA acknowledges CMS's proposal to remove the following measures from the Hospital IQR Program:

- Hospital Commitment to Health Equity (HCHE)
- COVID-19 Vaccination Coverage among Healthcare Personnel
- Screening for Social Drivers of Health (SDOH-1)
- Screen Positive Rate for Social Drivers of Health (SDOH-2)

NRHA supports efforts to reduce unnecessary reporting burden, particularly where structural or administrative measures do not directly contribute to care improvement or patient outcomes. The HCHE measure, for example, requires documentation of strategic priorities that may not reflect day-to-day care delivery in rural settings, where hospitals often operate with minimal administrative capacity.

While NRHA agrees that tracking COVID-19 vaccination coverage was essential during the Public Health Emergency, NRHA understands CMS's rationale for removing the measure at this time, given the evolving public health context and ongoing workforce pressures faced by rural facilities.

4a. Proposed Removal of Two Social Drivers of Health Measures Beginning with the CY 2024 Reporting Period/FY 2026 Payment Determination

NRHA is more cautious, however, regarding the proposed removal of the SDOH-1 and SDOH-2 measures. Understanding and addressing patients' social drivers of health remains an important part of improving care in rural communities. However, rural hospitals frequently lack the workforce, referral networks, and data systems needed to collect and act on SDOH data in a consistent and scalable way.

If CMS moves forward with removing these measures, NRHA urges the agency to continue engaging rural stakeholders in the development of future tools or supports that enable meaningful SDOH screening and response capacity in low-resource settings. NRHA also encourages CMS to explore community-based or population-level measures that reflect broader determinants of health without placing undue burden on small hospitals. NRHA appreciates CMS's effort to refine the IQR Program and reduce complexity while continuing to explore meaningful ways to promote person-centered, high-quality care.

These measures screen for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety, which significantly contribute to the outlined vision and goals within the Make America Healthy Again (MAHA) initiative to address chronic disease and improve health outcomes.[7] Growing evidence demonstrates that specific social risk factors are directly associated with patient health outcomes as well as healthcare utilization, costs, and performance in quality-based payment programs.[8] Social drivers of health negatively impact a person's health or

[7] THE WHITE HOUSE, *Establishing the President's Make America Healthy Again Commission*, (Feb. 2, 2025) https://www.whitehouse.gov/presidential-actions/2025/02/establishing-the-presidents-make-america-healthy-again-commission/.

[8] OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *Social Risk Factors and Medicare's Value-Based Purchasing Programs*, https://aspe.hhs.gov/topics/health-health-care/social-drivers-health/social-risk-factors-medicares-value-based-purchasing-programs.

healthcare and are significant risk factors associated with worse health outcomes as well as increased healthcare utilization. Consistent collection of high-quality data on SDOH and understanding how many patients experience challenges in these areas will enable clinicians to work together with patients, leveraging community support services and resources to manage chronic disease and improve health outcomes.

Screening for health-related social needs during inpatient hospitalization is especially critical in rural settings, where patients often face heightened barriers to food, housing, transportation, and utility access. Integrating SDOH screening into discharge planning allows rural providers to identify needs early and connect patients with community-based supports—when available—helping prevent readmissions, improve chronic disease management, and strengthen long-term health outcomes. These efforts directly support rural hospital quality performance, particularly in facilities where resource constraints demand efficient, targeted care planning.

Incorporating SDOH screening into inpatient care can also alleviate provider burden by offering structured, proactive ways to address factors contributing to poor outcomes. For rural clinicians, who often operate in understaffed environments, this systematic approach helps align limited care coordination resources with patients' greatest non-clinical risks.

Access to high-quality, standardized SDOH data also enables local, state, and federal agencies to better understand rural-specific social risk trends. Consistent documentation and reporting mechanisms are essential to developing actionable rural health policies that reduce healthcare costs, promote patient-centered care, and improve health system performance across geographically isolated regions.

Removing these measures would undermine national and local efforts to address chronic disease through integrated social and clinical care approaches. NRHA supports initiatives that advance the routine use of SDOH data in rural health care settings and welcomes collaboration with CMS on policies that promote cross-sector partnerships, patient trust, and data-driven innovation to improve rural health outcomes.

XI. Other Provisions Included in This Proposed Rule.

A. Proposed Transforming Episode Accountability Model (TEAM).

CMS finalized a new mandatory episode-based payment model, TEAM, in the FY 2025 IPPS final rule. This model will operate for five years, beginning January 1, 2026, and is designed to evaluate whether episode-based payment linked with quality measure performance reduces Medicare spending and improves quality of care. TEAM will test five surgical episodes. Participants are selected based on their location in a designated core-based statistical area (CBSA).

NRHA understands CMS's aim to include providers and beneficiaries who are often underrepresented in voluntary models, such as rural and safety net hospitals. However, **NRHA remains firmly opposed to mandatory participation for rural hospitals.** Many rural facilities do not have the infrastructure, staffing, or financial reserves needed to participate effectively in risk-based models. Low patient volume, limited administrative capacity, and narrow margins make these hospitals particularly vulnerable under a model like TEAM.

While NRHA supports thoughtful rural inclusion in value-based care, participation must be voluntary and accompanied by appropriate safeguards. The current proposal does not finalize low-volume

protections, opt-out flexibility, or rural-specific support pathways. Without these, TEAM risks destabilizing the very providers it intends to support.

2. TEAM Provisions of this Proposed Rule.

CMS is interested in testing mandatory episode-based payment in selected geographic areas. CMS chose a mandatory model to ensure meaningful evaluation findings and to include rural and underserved areas, which are often underrepresented in voluntary models. CMS has specifically stated its intent to include rural hospitals in TEAM. Participants are selected based on CBSA location. These geographic areas are made up of Metropolitan Statistical Areas (MSAs) and Micropolitan Statistical Areas (mSAs), which consist of one or more counties associated with a core population of at least 10,000 and neighboring counties with strong economic and social integration. This structure brings a number of rural hospitals into the TEAM model.

While NRHA stresses the importance of integration of rural providers into value-based care models, we only supported rural inclusion when participation is voluntary.[9] NRHA does not believe rural hospitals should be mandated to participate in TEAM at this time given the well-documented challenges with provider readiness, staffing shortages, and infrastructure limitations. NRHA believes that success in value-based care models requires thoughtful, flexible inclusion of rural providers. Unfortunately, many rural hospitals are not currently equipped to participate in mandatory, risk-bearing models—even with support. As such, CMS must allow rural hospitals to opt out of TEAM if they are located in a selected CBSA.

Mandating rural hospital participation is problematic because of the unique characteristics of these hospitals. Rural hospitals generally serve geographically dispersed communities with lower patient volumes, making them vulnerable to the statistical volatility and financial risks of episode-based models. These hospitals also tend to have fewer financial reserves, limited access to capital, and staffing constraints that make it difficult to manage new care delivery expectations and complex payment reconciliations. Any downside risk, as required under TEAM, is especially difficult for rural hospitals to absorb. These providers are typically poorly capitalized and under-resourced, leaving little room for error in any given performance year. Rural hospitals also face challenges in meeting the data collection and reporting requirements associated with TEAM, and many lack internal analytics or care management teams to support model participation.

NRHA supports several CMS proposals that make important policy changes to TEAM, including:

- Provide a one-year deferment from required participation for hospitals that become newly eligible after December 31, 2024. This is particularly important in the case of Critical Access Hospitals that convert to PPS status and suddenly meet TEAM eligibility criteria.
- Expanding the skilled nursing facility 3-day hospitalization rule waiver to swing bed admissions, a policy change needed for rural hospitals where swing beds are often the only post-acute care option.
- Continued inclusion of MDHs, SCHs, and rural safety net hospitals in Track 2 of TEAM, which includes a lower-risk structure.

Further, NRHA recommends two changes to the Track 2 TEAM structure. First, given the potential lapse of MDH status discussed above, NRHA urges CMS to treat rural hospitals as MDHs if they held such designation during the previous performance year. The policy put forth by CMS would disqualify

[9] https://www.ruralhealth.us/getmedia/fdb027e0-cd6e-42a6-8874-a965c1f8084e/NRHA-FY25-IPPS-comment-6-10-2024.pdf.

certain hospitals from being eligible for Track 2 based on the timing of congressional action to extend the MDH designation. CMS proposes to determine hospital eligibility for Track 2 based on whether the hospital is considered rural and designated as an MDH as of November 15, 2026. If the MDH designation is not extended by Congress by that date then the hospital will not qualify for Track 2, unless it is also considered a safety net hospital. MDHs should not be disqualified from TEAM flexibilities because of unpredictable congressional action.

Second, NRHA urges CMS to grant a longer glidepath to downside risk to rural hospitals, MDHs, and SCHs. Again, NRHA appreciates that MDHs and SCHs may choose to stay in Track 2, with limited downside risk, for performance year 2-5. However, safety net hospitals are able to remain in Track 1 for performance years 1-3 and NRHA believes that rural hospitals should have this option as well. MDHs and SCHs are safety nets in their communities and should be afforded the same flexibility.

CMS does not propose a low-volume policy in this rule but instead seeks comment on several options. These include exempting low-volume hospitals from downside risk in specific episode categories, establishing a rural- and safety net-only low-volume exception, and exempting hospitals that did not meet baseline thresholds. NRHA asks that CMS exempt rural hospitals with low volumes for the selected procedures from participating in TEAM.

NRHA stresses that CMS must also monitor how rural providers are impacted by changes in TEAM's risk adjustment approach. While NRHA supports replacing the Area Deprivation Index (ADI) with the Community Deprivation Index (CDI), CMS must ensure that the revised methodology appropriately captures rural social and economic disadvantages.

NRHA continues to emphasize that episode-based models must accommodate varying levels of familiarity with and capacity for financial risk. NRHA appreciates that CMS proposed to maintain Track 2, which includes a 10% cap on downside risk for eligible hospitals. To further support rural participation, NRHA recommends expanding the upside risk potential in Track 2 to 20% while retaining the 10% loss cap. The reward must be commensurate with the risk, especially for small rural providers who are being mandated to participate. Rural hospitals cannot assume risk at the scale of large systems and should not be expected to do so under a mandatory model.

10. Effects of the Transforming Episode Accountability Model (TEAM).

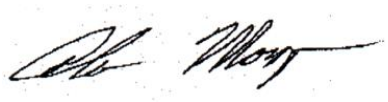
While NRHA continues to oppose the mandatory inclusion of rural hospitals in TEAM, we recognize and support certain refinements to the model that reflect a better understanding of rural care realities. One such refinement is CMS's proposal to expand the existing 3-day SNF rule waiver to include swing bed admissions for TEAM beneficiaries discharged to rural hospitals and CAHs.

Swing beds are often the only available post-acute care option in rural communities. The ability for rural hospitals to utilize swing beds without requiring a preceding 3-day inpatient hospital stay is an important change that can improve care transitions, reduce unnecessarily long hospital stays, and increase access to post-acute services for Medicare beneficiaries closer to home. This policy also helps to uphold beneficiary freedom of choice, particularly for those in rural or underserved areas who would otherwise face long travel distances or delayed discharges due to the absence of available in a SNF facility. While NRHA maintains broader concerns about TEAM's mandatory structure and risk-bearing requirements, we appreciate CMS's continued efforts to make specific policy adjustments, such as this waiver expansion, that reflect rural delivery system realities and improve patient-centered outcomes.

NRHA supports this proposed expansion of the 3-day SNF rule waiver and advocates for it to be expanded to Medicare beneficiaries outside of the TEAM model, as it was during the COVID-19 public health emergency, facilitating timely transfers and freeing up much needed inpatient beds. Expanding the waiver of the 3-day hospitalization is in the best interest of rural beneficiaries as they would be able to receive care when showing signs of declining health without waiting to deteriorate further or get sicker. Preventatively admitting patients in SNFs and swing beds would ultimately achieve savings for providers, CMS, and beneficiaries, while supporting access and quality for patients.

Thank you for the chance to offer comments on this proposed rule 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.

Sincerely,



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