

June 9, 2026

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

RE: CMS-1849-P; Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 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) Classifications and Relative Weights

NRHA has longstanding concerns about the disproportionate impact of annual MS-DRG recalibration and associated budget neutrality adjustments on rural hospitals. These methodological changes, while intended to be budget neutral in the aggregate, have consistently produced systematic payment disadvantages for rural providers. The FY 2027 proposed rule's impact tables show estimated effects of MS-DRG weight changes and budget neutrality adjustments estimated at -0.5% for all rural, -0.3% for sole community hospitals (SCHs) and -0.5% for Medicare-dependent hospitals (MDHs).

This is not an isolated year. From FY 2014 through FY 2021, CMS' impact tables revealed a consistent trend in which rural hospitals experienced greater negative impacts from MS-DRG recalibrations than their urban counterparts. The FY 2026 proposed rule showed a -0.5% impact for all rural hospitals and a -0.6% for SCHs. The pattern briefly moderated in FY 2022 and FY 2023, likely due to the use of modified FY 2019 discharge data during those years, but reemerged once CMS returned to standard discharge data. The FY 2025, FY 2026, and now FY 2027 rules all show rural hospitals again absorbing disproportionate negative impacts relative to urban hospitals.

As lower acuity cases continue to migrate out of the inpatient setting and into less costly sites of service, the relative weights for lower acuity MS-DRG decline while weights for higher acuity MS-DRGs increase. Rural hospitals, SCHs, and MDHs treat a disproportionately high share of lower acuity

patients and often are not the specialized care setting used to treat many higher acuity cases, which are typically referred to larger facilities often located in urban areas. As a result, rural hospitals are systemically unable to benefit from rising relative weights for complex cases while absorbing the weight reductions for lower acuity cases they predominately treat.

To protect the viability of rural hospitals, it is essential that CMS examine how its current rate-setting methodology contributes to disproportionate disadvantages to rural hospitals. Should this examination reveal such systematic, negative impacts on rural hospitals, CMS should consider making payment methodology adjustments.

One model worth considering is a case mix index (CMI)-based payment adjustment analogous to the low wage index hospital policy adopted in the FY 2020 IPPS final rule. That policy increased wage index values for hospitals in the bottom quartile to help them escape a self-reinforcing "downward spiral" in which suppressed wages made it harder to recruit staff, further suppressing wages. Rural hospitals face a comparable dynamic with CMI: persistently low case-mix limits revenue available to invest in technology, capital equipment, and specialty capacity, which in turn limits their ability to treat higher-acuity cases and improve their CMI. CMS has authority to make such an adjustment under Section 1886(d)(5)(I)(i) of the Social Security Act, which authorizes the Secretary to make "other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate," and has precedent for doing so in the MS-DRG context.¹

IV. Proposed Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2027 (§ 412.106)

E. Uncompensated Care Payments

NRHA is concerned about the proposed reduction in uncompensated care payments (UCP) for FY 2027. For FY 2027, CMS proposes total uncompensated care-based payments of approximately \$7.46 billion, a reduction of roughly \$250 million, or approximately 3.3%, from the FY 2026 level of \$7.71 billion. For rural hospitals, this decrease is even more drastic. CMS projects that rural hospitals will experience an -8.5% reduction in UCPs. This disparity is particularly troublesome given that small rural hospitals are already among the most financially vulnerable providers in the Medicare program.²

NRHA is concerned that CMS's continued reliance on Worksheet S-10 data and multi-year averaging methodologies may not adequately capture emerging uncompensated care pressures facing rural hospitals in real time. Smaller rural PPS hospitals often experience greater fluctuations in patient volume, payer mix, and uncompensated care costs than larger urban systems, while also operating with more limited administrative and revenue cycle capacity to ensure accurate and complete cost report submissions, including on Worksheet S-10. These factors may contribute to disproportionate

¹ 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" https://www.ssa.gov/OP_Home/ssact/title18/1886.htm#:~:text=The%20Secretary%20shall%20provide%20by%20regulation%20for%20such%20other%20exceptions%20and%20adjustments%20to%20such%20payment%20amounts%20under%20this%20subsection%20as%20the%20Secretary%20deems%20appropriate).

² Medicare Payment Advisory Commission. (2026, March). Report to the Congress: Medicare payment policy (Chapter 3: Hospital inpatient and outpatient services). https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch3_MedPAC_Report_To_Congress_SEC.pdf.

variability in uncompensated care payment allocations among rural providers and may understate the true uncompensated care burden carried by rural providers, thus skewing UCP payments and leading to the large decrease proposed for FY 2027.

Given these concerns, NRHA makes the following recommendations regarding FY 2027 uncompensated care payments.

- CMS should update Factor 2 projections in the Final Rule using the most recent available data on uninsurance trends, with particular attention to any Medicaid policy changes enacted between the proposed and final rules that could materially affect the uninsured rate.
- CMS should provide greater transparency in the Final Rule regarding the data sources that lead the agency to propose drastic reductions in UCP payments to rural hospitals. CMS should continue evaluating whether the Worksheet S-10 methodology and multi-year averaging approach appropriately reflect the financial realities facing rural hospitals and should consider targeted improvements to support more accurate and timely capture of rural uncompensated care costs. Given the projected 8.5% reduction in uncompensated care payments for small rural hospitals, more than twice the reduction projected for urban hospitals, NRHA urges CMS to consider whether additional adjustments or protections are warranted to prevent further destabilization of these already vulnerable providers.

V. Other Decisions and Changes to the IPPS for Operating Costs

B. Proposed Changes in the Inpatient Hospital Update for FY 2027 (§ 412.64(d))

1. Proposed FY 2027 Inpatient Hospital Update

NRHA thanks CMS for the proposed 2.4% payment update for hospitals. However, it is projected that rural hospitals across the board will see closer to a 0.8% increase in payment when all adjustments are applied. NRHA finds this update is inadequate given inflation, workforce shortages, and labor and supply chain cost pressures that rural hospitals continue to face. Rural PPS hospitals are struggling the most in comparison to other rural hospitals. The projected payment increase is not adequate to mitigate the vulnerabilities faced by rural PPS hospitals. Since 2010, more than 200 rural hospitals have closed or ceased inpatient services³ and another 432 additional hospitals are vulnerable to closure.⁴ The majority of these closures and conversions have been among rural PPS hospitals compared to critical access hospitals.⁵ Further, nearly 50% of rural hospitals are operating with negative margins, and the median operating margin for rural hospitals is 1%.⁶ 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

³ 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/>.

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

⁵ N.C. Rural Health Research Center, *supra* note 2.

⁶ 2025 rural health state of the state. 2025. Chartis. <https://www.chartis.com/insights/2025-rural-health-state-state>.

exceptions or adjustments to payments under subsection (d) as deemed necessary.⁷ This would 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 is needed to protect rural hospitals and mitigate the rural hospital closure crisis.

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

Rural America faces a deepening physician shortage that threatens the long-term viability of rural health care access. Growing the rural physician pipeline by training residents in rural settings is one of the most effective long-term strategies to address this shortage. SCHs and MDHs paid under the hospital-specific rate currently do not receive indirect medical education (IME) payments. SCHs and MDHs represent approximately 80 percent of rural hospitals that are eligible to establish residency training programs, yet the current payment framework provides them with no IME reimbursement when paid under their hospital-specific rate.⁸ This creates a powerful financial disincentive for these resource-limited hospitals to invest in residency training, even when they have the clinical capacity and community need to do so.

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 hospital-specific rate receive IME, which would constitute a major step towards encouraging more physician training in rural areas. A rural hospital that is already operating on a thin or negative margin cannot be expected to absorb the costs of establishing and maintaining a residency program without the IME support that other IPPS hospitals receive as a matter of course. NRHA stands ready to work with CMS to develop a workable methodology for extending IME payments to these providers and urges the agency to prioritize this issue in future rulemaking.

3. Proposed Modifications to the Criteria for New Residency Programs.

First, NRHA believes that CMS should defer to accrediting bodies' expertise when determining newness. Initial accreditation by a body such as the ACGME is sufficient to determine that a program is "truly new." However, given CMS' clear interest in delineating updated standards for new programs, **NRHA agrees that small programs should be defined in order to be exempted from new resident thresholds.**

NRHA supports CMS' proposal to remove the restriction preventing new residency programs from hiring experienced faculty or program directors. Under the current rules, a residency program must have a new director, new teaching staff, and new residents to qualify as "new" for purposes of GME and IME FTE cap adjustments. CMS has correctly identified this restriction as unnecessarily burdensome, particularly for rural hospitals that face acute challenges in recruiting qualified faculty

⁷ 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").

⁸ Alliance for Rural Hospital Access, SCHs, MDHs Can Improve Rural Physician Shortages, https://ruralhospitalaccess.org/wpcontent/uploads/2023/05/PositionPaper_118thCongressTrainingPrograms_Sept2023Update.pdf.

and program leadership. Rural hospitals interested in launching residency programs are frequently unable to attract newly trained program directors who lack established community ties or prior rural practice experience. Allowing programs to hire experienced faculty without jeopardizing their "new program" designation removes a significant structural barrier to rural residency development and will help more rural hospitals take their first steps toward building a physician training infrastructure. NRHA encourages CMS to finalize this proposal and to monitor its impact on rural residency program formation in subsequent years.

NRHA understands CMS's rationale for proposing that at least 90% of residents in a new program must not have prior training experience in the same specialty as a safeguard against hospitals shifting existing programs or duplicating cap slots. Further, NRHA urges CMS to finalize the proposed exception for small residency programs. Rural hospitals launching new programs often operate in markets with limited resident applicant pools and may have greater difficulty meeting a 90% threshold than larger urban programs with access to deeper applicant pipelines. As such, we support CMS' proposal to exempt residency programs with 16 or fewer residents from this standard.

G. Reasonable Cost Payment for Nursing and Allied Health Education Programs (§ 413.85 and § 413.87)

NRHA supports continued reasonable cost reimbursement for nursing and allied health education programs. Rural hospitals frequently serve as critical training sites for nurses, medical assistants, and allied health professionals, yet face persistent workforce shortages and financial pressures that limit their capacity to expand training without adequate reimbursement support. As the rural health care workforce crisis deepens, these programs represent an important pipeline for local recruitment and retention. NRHA encourages CMS to continue evaluating opportunities to strengthen reimbursement for rural training programs and to consider whether current reasonable cost methodologies adequately capture the true costs rural hospitals incur in supporting the full range of clinical education.

L. Rural Community Hospital Demonstration Program

NRHA strongly supports continued extension of the Rural Community Hospital Demonstration (RHCD) Program and urges CMS to work with Congress to ensure its reauthorization without interruption.

RCHD tests the feasibility of cost-based reimbursement for small rural hospitals that do not qualify for the critical access hospital designation. Participating hospitals receive cost-based reimbursement for inpatient and swing bed services, helping to create financial stability, support overall operations and sustain unprofitable services. Without the demonstration, many of these hospitals would face payment rates that do not cover the actual costs of providing care to their predominately Medicare and Medicaid patient populations. In turn, participation in the RCHD has helped rural hospitals remain open to serve rural beneficiaries.

Despite its importance for participating hospitals, RCHD is time limited. Originally created in 2004 as a 5-year program through the Medicare Modernization Act, RCHD has been subsequently extended for additional 5-year periods. The most recent extension mandated another 5-year extension through June 30, 2028. However, some hospitals' agreements to participate in the RCHD end before the program itself expires in June 2028. Rural hospitals have already begun to cycle out of the program, and CMS has not agreed to renew their participation through the program's end. CMS told impacted RCHD hospitals that Congress must reauthorize the program before they can renew their

participation through the end of the current program period despite the fact that RCHD's authorization does not expire for another two years.

NRHA urges CMS to take the following actions with respect to RCHD:

- Allow RCHD hospitals whose participation agreements expired in 2025 and 2026 to reenter the program until it lapses in June 2028. NRHA firmly believes the authorizing statute does not prohibit this action.
- Actively support Congressional reauthorization of the demonstration program and communicate clearly to Congress the program's role in preserving access to care in vulnerable rural communities.
- In the event of a lapse in Congressional reauthorization, take prompt action to expedite retroactive restoration of demonstration payments, consistent with NRHA's broader recommendations regarding lapsed rural payment programs discussed elsewhere in these comments.
- Provide participating hospitals with timely and transparent communication regarding payment calculations and any methodology updates that may affect their demonstration payments.

NRHA appreciates CMS's ongoing administration of this program and looks forward to continuing to work with the agency to ensure its long-term success.

IX. Proposed Quality Data Reporting Requirements for Specific Providers

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

CMS proposes to expand the five condition-specific mortality measures and three Excess Days in Acute Care after Hospitalization measures to include Medicare Advantage beneficiaries beginning with the FY 2028 payment determination for IQR and the FY 2032 program year for VBP. While NRHA supports the goal of ensuring quality measures reflect the full Medicare population, we have serious concerns about proceeding with this expansion before several foundational methodological issues are resolved.

First, MA encounter data reliability remains an unresolved problem. Unlike standardized fee-for-service claims, MA encounter data are generated by numerous private plans with varying coding methodologies, submission practices, and oversight mechanisms. Persistent questions about the accuracy and completeness of MA encounter data for quality measurement purposes have not been adequately addressed. Rural hospitals, which often have limited leverage with MA plans and smaller patient populations that are more sensitive to data errors, face disproportionate risk from inaccurate encounter data affecting their performance scores.

Excess Days in Acute Care measures present a specific equity problem for rural hospitals when applied to MA populations. Post-discharge utilization for MA beneficiaries is heavily shaped by plan-specific prior authorization requirements, post-acute network restrictions, and benefit structures. These are generally factors entirely outside the hospital's control. In rural markets, where post-acute care options are already constrained and MA network adequacy is frequently suboptimal, hospitals routinely face delays in timely post-acute placement driven by plan operational barriers rather than any deficiency in care coordination. Holding rural hospitals accountable for excess acute care days attributable to MA plan practices is both methodologically unsound and inequitable.

MA market penetration varies significantly across hospital markets, with rural areas experiencing particularly wide variation. Hospitals in high-MA-penetration markets may face disproportionate impacts compared to hospitals in lower-penetration areas, raising comparability and fairness concerns across rural markets specifically.

NRHA urges CMS not to finalize the incorporation of MA data into these measures for payment adjustment purposes until the agency has demonstrated that: 1) MA encounter data meet the same reliability and completeness standards as fee-for-service claims, 2) developed risk adjustment approaches that adequately account for MA-specific coding patterns, and 3) publicly released comprehensive hospital-specific impact analyses showing how inclusion of MA data would affect individual hospital scores and payment adjustments across different market types.

Finally, NRHA is concerned that CMS has not provided sufficient transparency regarding how inclusion of MA data would affect existing measure performance, hospital scores or payment adjustments. Before finalizing such a significant methodological change, CMS should provide extensive hospital-specific impact analyses and stratified comparisons between fee-for-service and MA populations.

X. Other Provisions Included in This Proposed Rule

A. Proposed Changes to the Transforming Episode Accountability Model (TEAM)

NRHA continues to support thoughtful rural participation in value-based care models when participation structures appropriately reflect rural provider capacity and operational realities. As TEAM enters its first full performance year in 2026, we reiterate our continued concern about mandatory participation for rural hospitals and offer specific recommendations on the FY 2027 proposals below.

NRHA remains firmly opposed to mandatory participation in TEAM for rural hospitals. Many rural facilities continue to lack the infrastructure, staffing, financial reserves, and administrative capacity needed to participate effectively in risk-bearing episode-based models. Low patient volume makes rural hospitals particularly vulnerable to statistical volatility under episode-based payment, a single outlier case can have an outsized effect on a small hospital's episode spending results in a way that would be smoothed out in a larger urban hospital's portfolio. Limited access to capital, thin or negative operating margins, and constrained care management capacity further compound these challenges. NRHA reiterates its request that CMS allow rural hospitals located in selected Core-Based Statistical Areas (CBSAs) to opt out of mandatory TEAM participation, and that any future expansion of mandatory episode-based models to rural providers be preceded by a formal assessment of rural provider readiness and accompanied by meaningful financial protections and technical assistance.

NRHA strongly supports CMS' decision to expand the SNF 3-day hospitalization rule waiver to include swing bed admissions for TEAM beneficiaries in the FY 2026 rule. Swing beds are frequently the only available post-acute care option in rural communities, and the ability to discharge TEAM beneficiaries to swing beds without a preceding 3-day inpatient stay is a critical flexibility for rural hospitals managing episode costs and care transitions. NRHA further urges CMS to expand this waiver beyond the TEAM model to apply to all Medicare beneficiaries in rural areas, as was the case during the COVID-19 public health emergency. Broader availability of the swing bed waiver would improve care transitions, reduce unnecessarily prolonged inpatient stays, free up acute care beds, and improve access to post-acute services for rural Medicare beneficiaries, regardless of whether their hospital

participates in TEAM. The clinical and access rationale for this waiver is not limited to episode-based payment models, and rural beneficiaries outside of TEAM deserve the same flexibility.

NRHA reiterates its recommendation that CMS ensure MDHs and SCHs retain access to Track 2 of TEAM, which includes a lower-risk structure with a 10 percent cap on downside risk, regardless of whether the MDH designation is extended by Congress before the November 15, 2026 eligibility determination date. As NRHA noted in prior comment letters, tying Track 2 eligibility to the timing of Congressional action on MDH reauthorization creates an arbitrary and unpredictable barrier for hospitals whose TEAM participation structure should not be hostage to legislative timing. CMS should treat hospitals that held MDH designation during the previous performance year as eligible for Track 2 protections, providing a stable and predictable participation pathway for these vulnerable providers.

NRHA also reiterates its recommendation that CMS extend the Track 1 option, currently available to safety net hospitals for performance years 1 through 3, to rural hospitals, MDHs, and SCHs as well. MDHs and SCHs function as safety nets in their communities and should be afforded the same glidepath to downside risk exposure that CMS has already recognized is appropriate for safety net hospitals more broadly.

B. Proposed Revision to Provider-Based Location Criteria Regulations Applicable to Off-Campus Facilities or Organizations (§ 413.65)

2. Proposed Revision to the “Same Patient Population” Location Criteria.

Currently, off-campus inpatient facilities associated with a parent hospital may obtain provider-based status if they are within 35 miles of the main hospital. If the off-campus facility is more than 35 miles away, the facility may nonetheless receive provider-based status if at least 75% of the patients served by the facility or organization reside in the same zip code areas as at least 75% of the patients served by the main hospital or at least 75% of the patients served by the facility or organization who required the type of care furnished by the main provider received that care from that provider.

CMS proposes to narrow eligibility for off-campus inpatient provider-based departments by removing the latter option for obtaining such status (i.e., the “referral-based test”). NRHA does not support this proposal and does not believe that CMS provides a compelling basis for changing the current policy. CMS states that the referral-based methodology was originally intended for isolated outpatient sites and expresses concern that inpatient off-campus facilities may receive unwarranted payment advantages under the current policy.

NRHA does not believe that CMS’s characterization of the referral-based methodology creates unwarranted payment advantages for rural inpatient facilities. Rural referral patterns often differ substantially from urban referral patterns due to provider shortages, long travel distance, and limited specialty availability. Rural patients frequently travel outside their local zip code areas to receive specialty or inpatient services from referral hospitals that serve broad geographic regions. Restricting provider-based eligibility to the zip code method alone may fail to appropriately account for rural patient care patterns and regional referral networks.

NRHA urges CMS to maintain the existing referral base test or establish a rural exception process that recognizes the unique referral and care delivery patterns present in rural communities. Removing this flexibility may reduce rural hospitals’ ability to maintain provider-based relationships necessary to preserve beneficiary access to care.

C. Proposed Expansion of the Comprehensive Joint Replacement (CJR) Model

1. Overview of Proposed Expansion of the Comprehensive Care for Joint Replacement (CJR) Model

NRHA appreciates CMS's commitment to value-based care and recognizes the agency's goal of improving quality and reducing costs for lower extremity joint replacement (LEJR) procedures. We also acknowledge that the original CJR model demonstrated meaningful savings; CMS reports net Medicare savings of \$112.7 million across performance years 6 and 7. However, NRHA has serious concerns about the proposed mandatory expansion of CJR into CJR-X and its implications for rural hospitals, SCHs, and MDHs. The financial, operational, and structural realities facing these providers are fundamentally different from the urban, high-volume hospitals that formed the core of the original CJR model, and the proposed CJR-X design does not adequately account for those differences.

NRHA's primary request is that CMS exempt SCHs and MDHs from mandatory participation in CJR-X and make participation voluntary for these providers. Rural hospitals are already contending with Medicare payment rates that frequently fall below the cost of care, significant losses on Medicare Advantage patients, Medicaid payment reductions following H.R. 1, and overall limited resources and staff. Layering mandatory downside risk exposure under CJR-X onto these pressures risks pushing financially fragile hospitals toward closure, worsening healthcare access for the communities that they serve. If CMS chooses not to exempt rural hospitals, SCHs, and MDHs from mandatory participation, NRHA urges the agency to at minimum implement the following rural protections.

A critical starting point for evaluating CJR-X's impact on rural hospitals is understanding how little experience SCHs and MDHs have with the original CJR model. The original CJR model mandated participation only in 67 randomly selected Metropolitan Statistical Areas (MSAs). As a result, there were only 5 SCHs and 5 MDHs participating in CJR during the first and second performance years, even fewer in the third performance year when CMS reduced the number of participating MSAs, and by the seventh and final performance year, there were no SCHs or MDHs participating in CJR at all.⁹ This near-total absence of SCH and MDH participation in the original model means there is no meaningful evidence base from which to predict how these hospitals will perform under CJR-X. Before requiring all SCHs and MDHs to participate in a mandatory downside risk model nationally, CMS should first collect sufficient data through TEAM to evaluate how rural hospitals perform under episode-based payment arrangements and what the impact is on patient access and quality of care in counties outside metropolitan statistical areas.

NRHA also urges CMS to shorten the proposed 90-day episode duration to 30 days for CJR-X. CMS itself acknowledges in the proposed rule that shorter episodes exhibit less spending variability, that unrelated medical events become more prevalent in the later stages of an episode, and that longer episodes increase the potential for overlap with other alternative payment models. Each of these concerns is amplified for rural hospitals. A 90-day episode window substantially increases the likelihood that spending on clinically unrelated services will be attributed to the rural hospital and counted against its episode target price. A 30-day episode duration is also consistent with the episode window used under TEAM and with the 30-day period used to measure readmission penalties under the Hospital Readmissions Reduction Program, providing greater coherence across Medicare's value-based payment programs. NRHA requests that CMS adopt a 30-day episode duration in the final CJR-X model, or at minimum commit to evaluating episode duration as a rural-specific modification in the first performance year.

⁹ CMS List of Hospitals Participating in CJR as of July 1 2024: <https://www.cms.gov/files/document/cjr-hospitallist-jul2024xls.xlsx>.

Finally, CMS proposes a 2% discount factor applied to CJR-X benchmark prices, which participants must achieve before qualifying for reconciliation payments. While NRHA appreciates that this is lower than discount factors used in some prior models, it remains a meaningful financial hurdle for rural hospitals operating on margins that are already thin or negative. NRHA urges CMS to reduce the discount factor to 1% or zero for SCHs, MDHs, and other rural hospitals participating in CJR-X. If CMS is unwilling to permanently reduce the discount factor, NRHA strongly encourages a phased approach in which the discount is reduced or eliminated in the early performance years of the model, allowing rural hospitals time to build the care coordination infrastructure, analytics capabilities, and clinical workflows needed to manage episode spending effectively before being held to the full financial standard. Reducing the early-year financial burden will allow rural hospitals to focus their limited resources on care quality improvement rather than financial risk management during the model's critical startup period.

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 Marguerite Peterseim at mpeterseim@ruralhealth.us.

Sincerely,



Alan Morgan
Chief Executive Officer
National Rural Health Association