ALLIANCE FOR RURAL HOSPITAL ACCESS

May 20, 2025

VIA REGULATIONS.GOV

Dr. Mehmet C. Oz, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850
Attention: CMS-1833-P

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 Rates; Requirements for Quality Programs; and Other Policy Changes [CMS–1833–P]

Dear Administrator Oz:

The Alliance for Rural Hospital Access (the Alliance) appreciates the opportunity to comment on the proposed Hospital Inpatient Prospective Payment System (IPPS) rule for FY 2026.

The Alliance is comprised of hospitals designated as Medicare-Dependent Hospitals (MDHs), Sole Community Hospitals (SCHs) and Rural Referral Centers (RRCs) under the Medicare program. MDHs, SCHs and RRCs provide rural populations with local access to a wide range of health care services. In doing so, MDHs, SCHs and RRCs localize care, minimize the need for further referrals and travel, and provide services at costs lower than their urban counterparts. These hospitals also commonly establish satellite sites and outreach clinics to provide primary and emergency care services to the surrounding underserved communities, a function which is becoming increasingly important as economic factors force many small rural hospitals to close.

Executive Summary

The Alliance urges CMS to take the following actions:

- **Transforming Episode Accountability Model (TEAM)**
  - CMS should exclude MDHs and SCHs from mandatory participation in TEAM, or at minimum, implement policies that give these hospitals a fair opportunity for success within the model.

- **Impact of MS-DRG and Relative Weight Changes and Corresponding Budget Neutrality Adjustments**

- CMS should examine how its current rate-setting methodology can contribute to disproportionate disadvantages to rural hospitals, including SCHs and RRCs.

- **Payment for Indirect and Direct Graduate Medical Education Costs (§§ 412.105 and 413.75 Through 413.83)**
  - CMS should use its authority to ensure SCHs and MDHs paid using their hospital-specific rate receive indirect medical education (IME) adjustments, to encourage these hospitals to localize resident training in rural areas.

- **Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2026 (§ 412.106)**
  - Similarly, CMS should use its authority to ensure SCHs and MDHs paid using their hospital-specific receive a DSH payment adjustment and an uncompensated care pool allocation, so that rural hospitals are reimbursed fairly for uncompensated care.

- **Proposed Changes in the Medicare-Dependent, Small Rural Hospital (MDH) Program (§ 412.108); Proposed Payment Adjustment for Low-Volume Hospitals (§ 412.101)**
  - With CMS currently unable to assume the extension of the MDH program and low-volume adjustment into FY 2026, CMS should explicitly clarify how it would handle the continuation of these programs should Congress enact legislation to extend them, as is anticipated.
  - CMS should also take steps to expedite the retroactive restoration of these programs, should the congressional calendar result in a temporary lapse in authorization.

Background on Rural Hospital Designations

Medicare Dependent Hospitals: The MDH program was established by Congress with the intent of supporting small rural hospitals for which Medicare patients make up a significant percentage of inpatient days and discharges. Because they primarily serve Medicare beneficiaries, MDHs rely heavily on Medicare reimbursement to sustain hospital operations. Consequently, these hospitals are more vulnerable to inadequate Medicare payments than other hospitals because they are less able to cross-subsidize inadequate Medicare payments with more generous payments from private payers. As such, Congress acknowledged the importance of Medicare reimbursement to MDHs and established special payment protections to buttress these hospitals. Congress recognized that if these hospitals were not financially viable and failed, Medicare beneficiaries would lose an important point of access to hospital services. To qualify as an MDH, a hospital must (1) be located in a rural area, (2) have no more than 100 beds, and (3) demonstrate that Medicare patients constitute at least 60 percent of its inpatient days or discharges.

Sole Community Hospitals: Congress created the SCH program to maintain access to needed health services for Medicare beneficiaries in isolated communities. The SCH program ensures the viability of hospitals that are geographically isolated and thus play a critical role in providing

access to care. Hospitals qualify for SCH status by demonstrating that because of distance or geographic boundaries between hospitals they are the sole source of hospital services available in a wide geographic area. There are a variety of ways in which hospitals can qualify for SCH status, but the majority qualify by being more than 35 miles from another provider.

Rural Referral Centers: Congress established the RRC program to support rural hospitals that treat a large number of complicated cases and function as regional referral centers. Generally, to be classified as an RRC, a hospital has to be physically located outside a Metropolitan Statistical Area (indicating an urban area) and either have at least 275 beds or meet certain case-mix or discharge criteria.

Transforming Episode Accountability Model (TEAM)

In the FY 2025 IPPS final rule, CMS finalized TEAM, a mandatory five-year episode-based payment model that requires acute care hospitals in selected core-based statistical areas to be responsible for the total cost of care during and for 30 days after five different surgical procedures. Selected hospitals will start in TEAM beginning January 1, 2026.

The Alliance commends CMS for its ongoing commitment to value-based care and is aligned with CMS's goals of improving quality and reducing costs. However, the Alliance remains deeply concerned with requiring MDHs and SCHs to participate in TEAM. As currently designed, TEAM risks accelerating the closure of these critical rural hospitals and worsening health outcomes for millions of Americans in medically underserved regions.

Rural hospital closures have profound economic and health consequences. Two recent studies provide compelling evidence of the harm caused by rural hospital closures. One study found that in communities that experienced a rural hospital closure, rates of preventable hospitalizations increased significantly up to two years after closure, signaling a decline in access to essential preventive and outpatient services.[1] Furthermore, a 2023 systematic review found that:[2]

- 89% of studies reported negative economic effects, including decreased income, population loss, and slowed economic growth;

- Unemployment rates increased by 1.6%-3.1% following rural hospital closures, particularly if the hospital was the sole hospital in the community. Moreover, decreases in health care employment had a spillover effect into non-health care sectors such as local construction, real estate, education, and other sectors;

- Residents experienced increased travel times of 11 to 15.7 minutes to the nearest emergency department, increasing barriers to timely care; and

[1] Khushalani, J. S., Holmes, M., Song, S., Arifkhanova, A., Randolph, R., Thomas, S., & Hall, D. M. (2023). *Impact of rural hospital closures on hospitalizations and associated outcomes for ambulatory and emergency care sensitive conditions*. The Journal of Rural Health, 39(1), 79–87. https://doi.org/10.1111/jrh.12671.
[2] Mills, C. A., Yeager, V. A., Unroe, K. T., Holmes, A., & Blackburn, J. (2023). *The impact of rural general hospital closures on communities—A systematic review of the literature*. The Journal of Rural Health, 40(2), 238–248. https://doi.org/10.1111/jrh.12810.

- Provider supply dropped significantly, with an estimated 8.3% decline in primary care physicians after a rural hospital closes.

These findings highlight the very real stakes federal policy decisions can have, which could inadvertently destabilize these institutions.

While CMS may be reluctant to revisit TEAM participant eligibility, the Alliance urges CMS to reconsider requiring MDHs and SCHs to participate in TEAM and instead allow them to opt in voluntarily. Based on an internal analysis, approximately 11% of hospitals required to participate in TEAM have SCH status and about 3% have MDH status. These hospitals serve geographically isolated communities, are structurally different from larger urban institutions, and often represent the only point of access to care for a wide swath of rural America. Moreover, these hospitals received special designations precisely because of their outsized importance to rural health and unique financial vulnerability.

CMS's own considerations regarding low-volume hospitals militate in favor of excluding MDHs and SCHs. CMS acknowledges in the proposed rule that low-volume hospitals tend to face unique challenges in managing financial risk under episode-based payment models. These hospitals often:

- Lack sufficient episode volume to spread financial risk or generate savings through care redesign;
- Are more financially vulnerable and disproportionately impacted by outlier cases;
- Have fewer resources and limited infrastructure to respond to the incentives of TEAM; and
- Face greater volatility in performance due to small denominators.

CMS considered but did not propose a range of alternative low-volume thresholds (i.e., 11, 21, 41, 51, 61, and 91 episodes) because of concerns about episode volatility, natural variation, and administrative burden. CMS also noted that such a policy could be especially relevant to rural and safety net hospitals like MDHs and SCHs.

Based on an analysis of claims data with a discharge date from October 1, 2021 through September 30, 2022, the average number of episodes per MDH and SCH by episode category was significantly below non-MDH/SCH hospitals as well as some of the thresholds that CMS considered.

	Average LEJR Episodes	Average SHFFT Episodes	Average CABG Episodes	Average Spinal Fusion Episodes	Average Major Bowel Procedure Episodes
MDH	74	17	1	8	11
SCH	120	36	9	21	22
All Others	170	39	17	50	31

Despite LEJR being somewhat higher for SCHs, these hospitals have low volumes across all other episode categories. Furthermore, these data reveal that MDHs and SCHs are unlikely to contribute meaningfully to CMS's cost savings in the model. An analysis of these same data indicates that only about 10% of all episodes would have been initiated by an MDH or SCH. Therefore, allowing MDHs and SCHs to opt out of the model would not significantly impact overall model savings and relieve CMS and these vulnerable rural providers from the administrative and financial burden of an unworkable participation requirement.

TEAM assumes all hospitals can absorb downside risk, coordinate complex specialty care across fragmented geographies, and invest in analytics and episode management infrastructure. For hospitals with MDH or SCH status, many of which operate with negative margins and limited capital, these assumptions simply do not hold true. CMS may believe that it does not need to act immediately given that the first performance year is upside only risk, but this perspective does not reflect the operational reality for small rural hospitals. These hospitals must begin planning and budgeting at least a year in advance of the performance year. That includes making decisions about whether to invest limited resources in preparing for downside risk or addressing pressing care delivery needs unique to their communities. Without timely action, MDHs and SCHs would be forced to participate in an experiment that could push them closer to financial collapse.

While we *strongly* urge CMS to omit SCHs and MDHs from TEAM, or to least make their participation voluntary, if CMS proceeds with requiring MDHs and SCHs to participate in TEAM, we encourage CMS to consider the following policy alternatives to mitigate the disproportionate burden placed on these hospitals:

- Extend safety-net protections to MDHs and SCHs. CMS has created important protections for safety-net providers under TEAM, including a longer glide path toward downside risk. As a matter of both policy and principle, MDHs and SCHs serve as de facto safety nets for their communities and should be granted similar treatment. CMS's current definition of a safety-net hospital is overly narrow and may inadvertently exclude the very facilities most critical to rural populations. Notably, about 24% of MDHs and SCHs meet TEAM's safety-net hospital definition. However, the vast majority (76%) do not qualify despite serving similar patient populations and facing the same constraints. Without policy intervention, these hospitals will not be afforded the same glide path and guardrails as their peers, leaving them exposed to disproportionate financial risk in TEAM.

- Reconsider hospital-level adjustments for MDHs and SCHs. We commend CMS for its ongoing efforts to incorporate hospital-level adjusters into TEAM's financial methodology. These adjustments represent a step toward acknowledging the unique challenges that smaller and rural hospitals face. However, the Alliance remains concerned that these adjustments are insufficient to ensure the participation and long-term viability of rural hospitals, particularly MDHs and SCHs. As noted previously, many MDHs and SCHs will not qualify for these adjustments despite facing financial and operational constraints similar to those that do qualify. The Alliance encourages CMS to consider additional refinements of the TEAM financial methodology for MDHs and

SCHs that both maintain the model's savings objectives and create a viable pathway for rural participation. For example:

- CMS should explore the feasibility of applying a reduced discount factor to MDHs and SCHs. These hospitals often operate with limited reserves and infrastructure, and may not be positioned to absorb the same level of discount as larger or better-resourced institutions. A reduced discount would recognize their resource constraints while still promoting efficiency and care transformation.

- CMS should explore developing an alternate track or methodology that adjusts benchmarks based on peer group performance or regionally adjusted comparisons. CMS acknowledged that its benchmarking methodology, which calculates the target price based on a reginal MS-DRG or HCPCS level, may create a ratcheting effect. Hospitals that succeed in reducing costs may find their future benchmarks lowered, creating a disincentive for continued participation. As more experienced and better-capitalized hospitals drive down benchmarks over time, MDHs and SCHs risk being disproportionately penalized.

- While we appreciate the inclusion of bed size adjusters, the safety-net adjusters exclude a significant portion of MDH and SCH hospitals (approximately 76% of MDH/SCH hospitals would not qualify for the safety-net adjustment) despite exhibiting similar financial and operational challenges. CMS should consider expanding the safety-net definition or introducing a separate adjuster specific to MDH and SCH status.

Additionally, we urge CMS to reconsider its proposal for how to treat MDHs in light of a potential lapse in their status and adopt a more stable and administratively workable approach. CMS proposes to determine a hospital's eligibility for Track 2 based, in part, on whether the hospital has rural status and is designated as a MDH as of November 15, 2026. Under this proposal, if the MDH program is not reauthorized by that date, a hospital that would otherwise be an MDH would not qualify for Track 2 absent meeting other eligibility criteria. This would be the case even if Congress later retroactively extends the MDH program, as it has often done in past years. CMS acknowledges this could disqualify certain hospitals based solely on the timing of congressional action, rather than the action itself. This creates considerable uncertainty for both CMS and MDHs. It also raises questions about how to treat hospitals that Congress ultimately confirms met the MDH criteria on the selection date, but were unable to attest to that status at the time due to a temporary lapse. Furthermore, it would be unfair to require MDHs to make binding decisions about model participation when their eligibility depends on the unpredictable timing of congressional action.

The Alliance recommends that CMS treat a hospital as an MDH for a given performance year, if it held such designation during a previous performance year (e.g., for 2027, CMS would look to 2026). This would provide consistency for CMS, and clarity and fairness for hospitals that have long operated in the MDH program. Moreover, this approach would provide a reasonable glide path into higher risk for any MDH that loses its MDH designation in the future. Allowing for a transitional period in TEAM would help stabilize their finances and operations as they adjust to

changes in their underlying Medicare reimbursement. Given that CMS estimates only four hospitals would be affected by this policy, applying this clarification would be narrowly targeted but highly impactful in promoting fairness and avoiding unnecessary exclusions.

Impact of MS-DRG and Relative Weight Changes and Corresponding Budget Neutrality Adjustments

Over the past decade, the Alliance periodically commented on the impact of annual MS-DRG changes—including changes to the relative weights that occur as part of recalibration, and the budget neutrality adjustment CMS applies to ensure that these changes do not increase payments from year-to-year—on rural hospitals.

From FY 2014 through FY 2021, there was an ongoing, concerning trend in which rural hospitals were systematically and disproportionately disadvantaged by annual MS-DRG changes. More recently, the trend of rural hospitals being disproportionately, negatively impacted by these adjustments appeared to be moderating. CMS's impact tables in the FY 2022 and FY 2023 proposed IPPS rules showed rural hospitals at near parity with urban hospitals with respect to impacts resulting from the MS-DRG changes.

At the time, the Alliance commented that, while it was pleased to see these moderating impacts, it was not aware of any specific steps CMS took to fix this longstanding issue. Rather, it appeared that those years had simply been less disadvantageous for rural hospitals and, as a result, the Alliance expressed ongoing concern that the systemic methodologies CMS uses to make these adjustments could cause adverse impacts again in the future.

Unfortunately, this concern appears to have been well-founded, as the impact tables in last year's FY 2025 rule and the current FY 2026 proposed rule again show that rural hospitals are being disproportionately, negatively impacted by annual MS-DRG changes. The FY 2026 proposed rule shows the following:

Hospital Type	**Proposed FY 2026 Weights and DRG Changes with Application of Budget Neutrality**
All Urban	0.0
All Rural	-0.4
RRC	-0.3
SCH	-0.6
RRC and SCH	-0.4

The return of these negative impacts further exacerbates the Alliance's overall, ongoing concern about the long-term sustainability and viability of its member hospitals—and *all* rural hospitals—and their ability to serve vulnerable communities.

CMS has repeatedly committed itself to supporting rural hospitals, yet this is an instance where CMS policy is doing the opposite. CMS has ample authority to make an adjustment under section 1886(d)(5)(I)(i) of the Social Security Act, which the Secretary has interpreted as

authorizing "other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate." CMS also has precedent for making such adjustments (CMS adjusted payments when it implemented the MS-DRGs relying in part on this authority).

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. Additionally, should this examination reveal such systematic, negative impacts on rural hospitals, CMS should consider making payment methodology adjustments.

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

The Alliance believes that the Social Security Act commands CMS to make additional payments to SCHs and MDHs that have teaching programs, beyond the hospital-specific rate. CMS is not presently doing this and the Alliance urges CMS to change how it applies these adjustments to these hospitals effective in FY 2026.

Section §1886(d)(5)(B) of the Social Security Act states, "[CMS] shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education…," without exception. SCHs and MDHs are subsection (d) hospitals. If they incur indirect costs of medical education, they must be given "an additional payment amount."

Commenters have previously urged CMS to make additional payments to hospitals paid on the basis of their hospital-specific rate. CMS has responded, "SCHs that are paid on the basis of their hospital-specific rate do not receive a separate IME add-on payment for Medicare Part A patient discharges because, generally the hospital-specific rate already reflects the additional costs that a teaching hospital incurs for its Medicare Part A patients." *See*, 79 *Fed. Reg.* 49,854, 50,002 (Aug 2022, 2014).

The Alliance does not agree that the hospital-specific rate "already reflects the additional costs that a teaching hospital incurs," and believe that CMS is acting contrary to the unambiguous text of the statute. The statute is clear on its face, CMS must "provide for an additional payment amount." Further, the statute prescribes how CMS is to provide for "the additional payment amount." Congress has articulated specific formulae for making the additional payment, and has refined the statutory formulae multiple times, with *increasing specificity*. Congress has been clear and prescriptive, and the statute leaves CMS no authority to deviate from those formulae and to determine its own methodology for providing the "additional payment amount."

In addition to not following the plain language of the statute, CMS's reasoning for deviating from those commands also is flawed. Hospital-specific rates are derived from hospital cost reports in specified years. For SCHs those years are 1982, 1987, 1996 or 2006; for MDHs, those years are 1982, 1987 or 2002. It is conceivable that hospitals with teaching programs in years that predated their hospital-specific rate base year had *some* of those costs reflected in their hospital-specific rates. Hospitals that developed teaching programs in years *after* their hospital-specific rate base year could not have those costs reflected in their hospital-specific rates. And any hospital that expanded its teaching program after its base year also does not have those costs

reflected in its hospital-specific rate.

There also is a compelling policy rationale for CMS to apply the statute as written. SCHs are often the sole source of care within and around a community. MDHs are, by definition, vital providers to the Medicare program. Beneficiaries who live in rural communities often depend on these facilities for a full complement of health care services, from primary care to sophisticated inpatient treatment. Rural hospitals continue to struggle financially, and when an MDH or SCH closes, the consequences for the communities they serve may be grave.

Moreover, rural health care workforce shortages are well-documented. SCHs and MDHs can help alleviate physician shortages by establishing teaching programs, if they have adequate resources to do so. Specifically, SCHs and MDHs are well-situated to host residency programs, but SCHs and MDHs paid on the basis of their hospital-specific rate are financially disincentivized to establish such programs.

SCHs and MDHs—which comprise nearly 80% of hospitals eligible to establish training programs in rural communities—should receive the same incentives and financial buffer as hospitals paid under the federal rate. Based on CMS cost report data, 58% of SCHs and 46% of MDHs are paid on the basis of their hospital-specific rate. This formula for SCHs and MDHs should not disqualify the hospital from receiving full IME payments as they would under the federal rate formula. This full federal funding of DME and IME payments is necessary to establish and operate rural-based residency training programs.

The Alliance urges CMS to use its authority to ensure SCHs and MDHs paid using their hospital-specific rate receive IME adjustments, to encourage these hospitals to localize resident training in rural areas.

Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2025 (§ 412.106)

Similarly, the Alliance believes that Social Security Act commands CMS to make additional payments to SCHs and MDHs that are DSH hospitals, beyond the hospital-specific rate. CMS is not presently doing this and the Alliance urges CMS to change how it applies these adjustments to these hospitals effective in FY 2026.

Section 1886(d)(5)(F) of the Social Security Act provides, "…the Secretary shall provide…for an additional payment amount for each subsection (d) hospital which…" meets criteria specified in the statute. According to this language, all subsection (d) hospitals that meet the criteria must receive an "additional payment amount." As with IME adjustments, this subparagraph provides very specific formulae for determining the "additional payment amount," and even provides very specific formulae applicable to SCHs and MDHs. CMS may not deviate from the unambiguous text of the statute and forego making the "additional payment amount." Moreover, because the cost of uninsured patients is not included in the federal DRG rate or SCH and MDH hospital-specific rates, it is not credible to say that a hospital's additional costs of treating this patient population are reflected in the hospital-specific rate. Thus, SCHs and MDHs deserve the DSH add-on to their hospital-specific rates just as other hospitals receive an add-on to the federal

DRG rate.

The Alliance urges CMS to use its authority to ensure SCHs and MDHs paid using their hospital-specific receive a DSH payment adjustment and an uncompensated care pool allocation, so that rural hospitals are reimbursed fairly for uncompensated care.

Proposed Changes in the Medicare-Dependent, Small Rural Hospital (MDH) Program (§ 412.108); Proposed Payment Adjustment for Low-Volume Hospitals (§ 412.101)

The MDH program was created by Congress nearly 35 years ago to support hospitals that are dependent upon Medicare reimbursement and are thus more vulnerable to inadequate Medicare payments than other hospitals, because they are less able to cross-subsidize inadequate Medicare payments with more generous payments from private payers. The program has been renewed periodically by Congress, and is due to expire on September 30, 2025, without further congressional action.

The Medicare low-volume hospital payment adjustment was created in 2005 and helps to level the playing field for hospitals in small, isolated communities whose operating costs often outpace their revenue. The low-volume adjustment has also been renewed over the years—in tandem with the MDH program—and is also due to expire on September 30, 2025, without further congressional action.

The Alliance is working with Congress to advance legislation that would extend the MDH program and the low-volume adjustment (namely, S. 335 and H.R. 1805). The loss of the MDH program and low-volume adjustment would have severe, adverse impacts on vulnerable rural hospitals and the communities they serve. In recent years, MDH and low-volume hospitals have operated under a near-constant uncertainty about the future of these programs. Such uncertainty has discouraged hospitals from making the types of capital and infrastructure investments necessary to expand services, modernize facilities, and focus on other improvements to patient care.

As hospitals finalize their FY 2026 budgets, they are not able to assume that these critical programs will be extended, and are therefore taking steps to account for this lost revenue and alleviate its impact.

The Alliance recognizes CMS regards these programs as ending on September 30, 2025, and that the agency typically does not create policy around actions Congress *may* take in the future. Nonetheless, the loss of these vital payments to a hospital and the community it serves can be profound, and there are steps CMS could take to minimize disruptions to beneficiary access to care. The Alliance urges CMS to explicitly clarify how it would handle the continuation of these programs should Congress enact legislation to extend them, as is anticipated.

In addition, CMS should also take steps to expedite the retroactive restoration of these programs, should the congressional calendar result in a temporary lapse in authorization. Past retroactive restorations have seen delays that caused significant cash flow problems to affected hospitals. If

Congress again acts to extend these programs, but does not do so until after the September 30, 2025, expiration date, the Alliance implores CMS to move expeditiously to restore payments, in order to ensure these rural facilities remain viable and are able to continue to provide quality care to their communities.

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Thank you for your consideration of these comments. Please contact me at 202.204.1457 or ezimmerman@mcdermottplus.com if you have any questions.

Sincerely,

Eric Zimmerman