ALLIANCE FOR RURAL HOSPITAL ACCESS

January 27, 2026

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

Re: Pre-Rulemaking Letter – FY 2027 Hospital Inpatient Prospective Payment System Proposed Rule

Dear Administrator Oz:

The Alliance for Rural Hospital Access (the Alliance) is submitting this letter as a pre-rulemaking request that the Centers for Medicare & Medicaid Services (CMS) propose a policy change in the forthcoming Hospital Inpatient Prospective Payment System (IPPS) proposed rule for FY 2027 to address work force challenges in rural communities.

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.

SCHs are often the sole source of care within and around a community, and 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 SCH or MDH closes, the consequences for the communities they serve, and especially for Medicare beneficiaries may be grave.

The Alliance recommends that CMS sustain and improve access to health care in rural communities by ensuring that SCHs and MDHs paid using their hospital-specific rate receive indirect medical education (IME) adjustments.

Rural health care workforce shortages are well-documented. Rural communities struggle to recruit and retain physicians, including most notably primary care physicians. Studies have shown that training physicians in rural areas increases the likelihood that those physicians will

practice in a rural community.[1] Yet, according to the Government Accountability Office, only two percent of residency training occurs in rural areas.[2] The Department of Health and Human Services (HHS) and public health advocates have recommended that more physician training be localized in rural areas. The Council on Graduate Medical Education (COGME)[3] in an April 2022 report to HHS and Congress recommended that CMS "eliminate regulatory and financial barriers that inhibit the development of rural residency programs" and "offer Medicare… exceptions for sponsoring institutions starting new rural-based training programs…in needed…geographic areas."[4]

SCHs and MDHs are well-situated to host residency programs. However, SCHs and MDHs are financially disincentivized from establishing teaching programs. Under the IPPS, SCHs and MDHs are paid the greater of the federal rate (i.e., the payment that the hospital would otherwise receive under the IPPS) or a cost-based payment, which is determined by adding together the federal payment rate applicable to the hospital and the amount that the federal payment rate is exceeded by a hospital-specific rate (in the case of MDHs, the hospital receives 75% of that difference). Under current Medicare policy, when an SCH or MDH paid on the basis of its hospital specific rate establishes a teaching program, it receives no extra adjustment/payment for the indirect costs of medical education.

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.

IPPS commenters have previously urged CMS to make additional IME payment adjustments 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." Hospital-specific rates are pegged to a hospital's costs in a specified year. For SCHs the years are 1982, 1987, 1996 or 2006; for MDHs the years are 1982, 1987 or 2002. If an SCH has a 1987 base year, for example,

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[1] Hempel S, Maggard Gibbons M, Ulloa JG, Macqueen I, Miake-Lye I, Beroes J, et al. Rural Healthcare Workforce: A Systematic Review. VA Evidence-based Synthesis Program Reports. Washington, DC: Department of Veterans Affairs; 2015. 79.1.

[2] United States Government Accountability Office. Graduate Medical Education: Programs and Residents Increased during Transition to Single Accreditor; Distribution Largely Unchanged. GAO-21-329, (April 2021) p.24.

[3] COGME was authorized by Congress to provide advice and recommendations to the Secretary and Congress on physician workforce trends, training issues, and financing policies.

[4] Council on Graduate Medical Education, Twenty-Fourth Report to the Secretary of the U.S. Department of Health and Human Services and the U.S. Congress, "Strengthening the Rural Health Workforce to Improve Health Outcomes in Rural Communities," (April 2022) p. 12.

and it established a teaching program in 1984, for example, then arguably the additional costs of that teaching program are reflected in that hospital's hospital specific rate. If, however, that hospital established a teaching program in any year after 1987, then the costs cannot be reflected in that hospital's hospital specific rate. And if the hospital with the teaching program established before 1987 ever expands its teaching program, the additional costs of that expansion also are not reflected in that hospital's hospital specific rate.

CMS has the authority to make this change. The Social Security Act envisions CMS would be making these additional payments to SCHs and MDHs that have teaching programs regardless of whether the hospital is paid on the basis of a hospital-specific rate. 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…." SCHs and MDHs are subsection (d) hospitals. If they incur indirect costs of medical education, they must be given "an additional payment amount." That clause within section §1886(d)(5)(B) provides no exception or discretion to omit SCHs and MDHs.

Congressional intent is clear here. The statute says 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."

For these reasons, the Alliance encourages CMS to use the authorities it has to fulfill a priority for this administration: improving access to healthcare in rural communities. The Alliance encourages CMS 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.

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Thank you for your consideration of this request. We appreciate the Trump Administration's commitment to improving rural health care, and believe that making this statutorily unambiguous adjustment would align nicely with these efforts to improve rural Americans' access to care.

We welcome the opportunity to meet with your team to discuss this issue further, prior to the release of the FY 2027 proposed rule, and will reach out to the appropriate member of your team to make such arrangements. If you have any questions, please contact me at 202.204.1457 or ezimmerman@mcdermottplus.com.

Sincerely,

Eric Zimmerman