June 2, 2026

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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-1849-P

Re: 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 [CMS 1849-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 2027.

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 healthcare 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:

- **Comprehensive Care for Joint Replacement CJR Expanded (CJR–X) Model**
  - CMS should exclude MDHs and SCHs from mandatory participation in CJR-X 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 MDHs and SCHs, and should make payment methodology adjustments to remedy these impacts.

- **Proposed Changes in the Medicare-Dependent, Small Rural Hospital (MDH) Program (§ 412.108); Proposed Payment Adjustment for Low-Volume Hospitals (§ 412.101)**
    - With CMS unable to assume the extension of the MDH program and low-volume adjustment beyond the first three months of FY 2027, and with the potential for lapses in these programs should congressional action to extend them be delayed, CMS should prepare to take prompter action to expedite the retroactive restoration of these important programs.

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% 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.

Comprehensive Care for Joint Replacement CJR Expanded (CJR–X) Model

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, we are concerned by CMS's proposal to impose another mandatory model on hospitals, especially MDHs and SCHs. The additional pressures CJR-X would impose on MDHs and SCHs risks increasing financial strain, accelerating closure rates, and worsening health access and outcomes for millions of Americans in medically underserved regions.

- We ask that CMS exempt MDHs and SCHs from mandatory participation in CJR-X and make their participation voluntary.

- If CMS chooses not to exempt MDHs and SCHs from required participation in CJR-X, then at a minimum CMS should:
    - Exempt MDHs and SCHs from downside risk until CMS has collected sufficient data through CJR-X and TEAM to evaluate the impacts of episode-based payments for lower-extremity joint replacement on patient access and quality of care for counties located outside of metropolitan statistical areas, and to evaluate the performance of SCHs and MDHs under these models; and
    - Incorporate more facility characteristics including whether the hospital is a SCH or MDH into risk adjustment when establishing target prices.
    - Increase the low-volume threshold to an empirically sound level. The current proposal to exclude hospitals with fewer than 31 episodes during the applicable baseline period from reconciliation is too low of an episode threshold.

- CMS should waive downside risk for all hospitals in their first performance year, consistent with the original CJR model.[1] When CMS originally implemented the Comprehensive Care for Joint Replacement model, CMS phased in financial risk starting in the second performance year. This allowed all hospitals more time to prepare for the model and to evaluate their performance without risk during the first performance year. Similarly, CMS should phase in financial risk for all hospitals, and if CMS does not exempt SCHs and MDHs from mandatory participation or downside risk, CMS should at least phase in downside risk for SCHs and MDHs under CJR-X.

The original CJR model only mandated participation in 67 randomly selected metropolitan statistical areas (MSAs). For the 3rd CJR performance year CMS scaled back mandatory participation to the 34 MSAs with the highest average episode spend, and for the 6th CJR performance year excluded rural and low-volume hospitals from the model.

- Most SCHs and MDHs are located outside MSAs and were therefore originally excused from CJR.

- Across all seven performance years, there were very few SCHs or MDHs participating in CJR. There were only 5 SCHs and 5 MDHs participating in CJR during the first and

[1] 80 FR 73280

second performance years,[2] and even fewer in the third performance year when CMS reduced the number of MSAs participating in CJR. As of the 7th and final performance year, there were no SCHs or MDHs participating in CJR.[3]

Given that so few SCHs and MDHs participated in the original CJR model, there is insufficient evidence to predict how these hospitals will fare under the new expanded model. Before requiring all SCHs and MDHs to participate in downside risk in CJR-X nationally, CMS needs to collect more information through TEAM and CJR-X showing how SCHs and MDHs perform under episode-based payment arrangements, including the impact on patient access and quality of care outside of metropolitan statistical areas.

Given the lack of historical experience in CJR for SCHs and MDHs, the closest proxy are safety net-hospitals. As a group, safety net hospitals fared poorly under the original CJR model. According to the Performance Year 7 evaluation report:

> "On average, safety-net hospitals (SNHs) in the CJR Model performed worse financially than non-SNHs. SNHs were substantially more likely than non-SNHs to owe repayments to Medicare. SNHs also had a lower volume of LEJR procedures than non-SNHs. They served a more complex patient population, with higher rates of patients with fractures, major comorbidities, and unmet nonmedical needs." [4]

The evaluation report also found that:

> "SNHs' lower volume and more complex episodes could have affected their ability to meet the CJR target price. As a result of their lower LEJR volume, SNHs may have anticipated low returns and not invested their limited resources in redesigning care for LEJRs. Among SNHs' LEJR episodes, a much larger proportion were a result of fractures, with fewer opportunities to intervene before surgery. Therefore, SNHs had more challenges affecting the care pathway for the patients they treated."[5]

Due to this relationship between episode volume and provider performance, CMS should raise the low-volume threshold that is used to exclude CJR-X participants from reconciliation. This threshold should be determined in an empirical manner, based on an analysis of hospital performance under CJR by total episode volume. This analysis should identify a low-volume

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[2] McDermott+ analysis of CMS Final Performance Years 1-7 Reconciliation Payments (XLSX) file for performance years 1, 2 and 3.

[3] McDermott+ analysis of CMS List of Hospitals Participating in CJR as of July 1 2024: https://www.cms.gov/files/document/cjr-hospitallist-jul2024xls.xlsx M+ confirmed that none of the 315 hospitals participating in CJR at that time are listed as sole community or Medicare Dependent Hospitals in the IPPS 2024 final rule impacts file, or the IPPS 2027 proposed rule impacts file. The CJR

[4] Markovitz A., Bijelic E., Hopewell C., Julius N., Christensen A., Schaefer MB., Lahiri S., Fate K., Morrall I., LaRocca C., Gass B. *Comprehensive Care for Joint Replacement Model Evaluation: Executive Summary Seventh Evaluation Report*. Lewin Group, December 2025. https://www.cms.gov/priorities/innovation/data-and-reports/2025/cjr-py7-ar-exec-sum

[5] Markovitz A., Bijelic E., Hopewell C., Julius N., Christensen A., Schaefer MB., Lahiri S., Fate K., Morrall I., LaRocca C., Gass B. *Comprehensive Care for Joint Replacement Model Evaluation: Executive Summary Seventh Evaluation Report*. Lewin Group, December 2025. https://www.cms.gov/priorities/innovation/data-and-reports/2025/cjr-py7-ar-exec-sum

threshold where hospitals above that threshold have shown that they are likely to keep standardized episode spending below the discounted target price and have more predictability in their performance year-over-year.

Given that SNHs performed poorly under CJR, it is encouraging that CMS is applying a 5% stop loss in CJR-X to MDHs and SCHs, among others. But more is needed to protect hospitals with MDH or SCH status. Many of these hospitals operate with negative margins, limited capital, and are likely to have limited resources that can be used to redesign care and invest in analytics and episode management infrastructure. Additional unmanageable financial strain on MDHs and SCHs could push them closer to financial collapse. 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.[6] Furthermore, a 2023 systematic review found that:

- 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 healthcare employment had a spillover effect into non-healthcare 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

- Provider supply dropped significantly, with an estimated 8.3% decline in primary care physicians after a rural hospital closes. [7]

These findings highlight the very real risk posed by CMS's proposal, which could inadvertently destabilize these institutions.

<u>As such, the Alliance urges CMS to make SCH and MDH participation in CJR-X voluntary. If CMS proceeds with requiring MDHs and SCHs to participate, we encourage CMS to implement the following policy alternatives to mitigate the disproportionate burden placed on these hospitals:</u>

- <u>Exempt SCHs and MDHs from downside risk until enough data has been collected through CJR-X and TEAM to evaluate the impact of episode-based payment models for</u>

[6] 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.
[7] 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.

lower-extremity joint replacement on patient access and quality of care for counties located outside of metropolitan statistical areas, and to evaluate the performance of SCHs and MDHs under these models.

- Incorporate more facility characteristics into risk adjustment that account for whether the anchor hospital is an SCH or an MDH when establishing target prices.

- Raise the low-volume threshold to an empirically sound level.

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 resulting 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. In FYs 2022 and 2023, the differences subsided. CMS's impact tables in the proposed IPPS rules for those two years showed rural hospitals at near parity with urban hospitals with respect to impacts resulting from the MS-DRG changes. This may have been due to the usage of FY 2019 discharge data in both FY 2021 and FY 2022 rate-setting and modifications made to the FY 2021 discharge data used for FY 2023 rate-setting.

Once CMS returned to normal discharge data usage, the problem has re-emerged. The impact tables in the FYs 2025 and 2026 final rules, and the current FY 2027 proposed rule show that rural hospitals are once again being disproportionately, negatively impacted by annual MS-DRG changes. The FY 2027 proposed rule shows the following impact experience:

Hospital Type	Proposed FY 2027 Weights and DRG Changes with Application of Budget Neutrality
All Urban	0.0%
All Rural	-0.5%
SCH	-0.3%
MDH	-0.5%

The Alliance is concerned that systemic adjustments are negatively impacting these hospitals and undermining the long-term sustainability and viability of these critical sources of rural healthcare.

The MS-DRG weighting system is constantly evolving as lower acuity cases are dropping out of the IPPS and moving to less costly sites of service. Rural hospitals, SCHs and MDHs have a lower average case-mix index (CMI) than other IPPS hospitals, indicating they provide care for a

higher percentage of lower acuity cases than their urban counterparts. Smaller, rural hospitals may not have the build-out and specialization to treat higher acuity cases. These cases would likely be referred to larger, urban hospitals.

As lower acuity cases drop out of the IPPS, the relative weights increase for an already costly MS-DRG will go up, while the relative weight for a less costly MS-DRG will go down. For example, under MS-DRG GROUPER V44 compared to MS-DRG GROUPER V43, the weight for MS-DRG 281 Acute Myocardial Infarction, Discharged Alive and with complications and comorbidities decreased by 0.1%. Conversely, the weight for the more costly MS-DRG 276 Cardiac Defibrillator Implant with Major Complications and Comorbidities or Carotid Sinus Neurostimulator increased by 4%. Rural hospitals, MDHs and SCHs will never realize the benefit of higher payment for higher acuity cases, as they continue to treat a higher proportion of lower acuity cases. These hospital types have a significantly higher proportion of case-mix indices in the bottom 5th percentile than urban hospitals. See table below.

		CMI MS-DRG V43		**CMI MS-DRG V44**	
Category	**N**	**Bottom 5th Percentile (n)**	**Bottom 5th Percentile (%)**	**Bottom 5th Percentile (n)**	**Bottom 5th Percentile (%)**
All IPPS	3,082	155	5.0%	155	5.0%
Rural	***679***	***88***	***13.0%***	***88***	***13.0%***
Urban	2,403	67	2.8%	67	2.8%
Special Types					
SCH	***255***	***26***	***10.2%***	***27***	***10.6%***
MDH	***160***	***23***	***14.4%***	***22***	***13.8%***

CMS has repeatedly committed itself to supporting rural hospitals, yet this is an instance where CMS policy is unintentionally doing the opposite. CMS should take steps to ensure that its policies are not systematically disadvantaging rural hospitals at a time when the agency is working hard to protect access to healthcare for rural communities.

To protect the viability of rural hospitals, the Alliance urges CMS to examine how its current rate-setting methodology is disadvantaging rural hospitals. If this examination reveals such systematic, negative impacts on rural hospitals, CMS should make payment methodology adjustments. Alternatively, if CMS finds it untenable to eliminate these impacts through changes to MS-DRG recalibration processes, then CMS should consider a policy that shifts payment to hospitals with CMIs in the lowest 5th percentile. Hospitals that treat a higher proportion of lower acuity patients associated with their location should not be perpetually penalized due to the nature of the MS-DRG weighting system.

CMS could implement a similar payment shift mechanism as the low-wage index policy. This policy, adopted in the FY 2020 IPPS final rule, increased the wage index for hospitals in the lowest quartile by raising each qualifying hospital's value by half the difference between its otherwise applicable wage index and the 25th-percentile wage index, while applying a budget-neutrality offset to other hospitals. CMS said the policy was intended to mitigate geographic wage disparities and help low-wage hospitals escape a payment-and-wage "downward spiral."

The "downward spiral" of low-wage index is similar to the downward spiral of CMI due to MS-DRG weight recalibration for rural hospitals. The hospitals with the lowest CMI will be at a continual disadvantage to invest in new technology, expensive capital equipment, and the best medical talent to be able to care for higher acuity cases as well as maintain their current level of healthcare offerings.

CMS has ample authority to make 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." CMS also has precedent for making such adjustments (CMS adjusted payments when it implemented the MS-DRGs relying in part on this authority). This authority is distinguishable from and more specifically appropriate for this circumstance than the authority relied upon to support the low-wage index adjustment.

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 40 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 December 31, 2026, 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 December 31, 2026, 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 patient care improvements.

The Alliance recognizes CMS regards these programs as ending on December 31, 2026, 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. If Congress momentarily allows these programs to lapse and CMS must temporarily terminate them, the agency should then also take steps to expedite the retroactive restoration of

these programs.

Past retroactive restorations have seen delays that caused significant cash flow problems to affected hospitals. Most recently, after the programs lapsed during the government shutdown that lasted from October 1, 2025, through November 12, 2025, hospitals that rely upon these payments were eagerly awaiting their retroactive restoration after the shutdown ended. The Change Request CMS sent to MACs was not issued until December 23, 2025, nearly six weeks after the shutdown ended and the programs were retroactively restored.

Next, the programs faced a January 30, 2026, cliff, and the legislation that extended them through their current deadline of December 31, 2026, was signed into law on February 3, 2026. Hospitals continued to face payment uncertainty while waiting for restored payments, as the next Change Request was not issued until March 27, 2026. MACs then often took weeks to restart the programs and corresponding payments, further compounding the hardship on the hospitals.

Regrettably, CMS is well experienced in restarting lapsed programs and can rely on past precedent to restart programs faster. If Congress again acts to extend these important programs, but does not do so until after the December 31, 2026, expiration date, the Alliance implores CMS to move more expeditiously to ensure that payments are promptly restored, 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