American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

August 5, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Agency Information Collection Activities: Proposed Collection CMS-10949

Dear Administrator Oz:

On behalf of our nearly 5,000 member hospitals, health systems and other healthcare organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers, and the 43,000 healthcare leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the substantial opportunity the Rural Health Transformation Program (RHTP) offers to bolster and modernize access to care in rural communities. To best accomplish this, we urge the Centers for Medicare & Medicaid Services (CMS) to ensure that funding be prioritized for and distributed to hospitals, which serve as the backbone of rural healthcare delivery, particularly by lifting the provider payments and infrastructure funding caps.

In rural communities across America, hospitals and health systems serve as cornerstones for their patients and communities' health and well-being. Rural hospitals and health systems provide much-needed access to affordable, quality healthcare for patients close to home. The importance of these hospitals cannot be overstated, as individuals living in these communities face greater challenges in accessing healthcare due to, for example, geographic isolation, a shortage of healthcare providers and a higher prevalence of chronic disease. They also rely more heavily on public payers — Medicare and Medicaid, which often reimburse less than the cost of caring for patients.[1] When rural hospitals close or curtail services, residents are forced to travel long distances for even basic treatment. Loss of such services also threatens the health and

[1] Kaiser Family Foundation. (Feb 2025). https://www.kff.org/health-costs/key-facts-about-hospitals/?entry=rural-hospitals-rural-discharges-by-payer

economic vitality of the entire community as hospitals support good-paying jobs and infuse the local economy with spending on goods and services. Incidentally, such economic stability itself is fundamental to individuals' health and wellbeing.[2]

Recognizing the vital role that rural hospitals play in their communities, Congress last year included $50 billion in RHTP funding to support rural providers. Lawmakers designed the fund with the intent of stabilizing, modernizing and sustaining rural *hospitals*, especially those facing financial distress and aging infrastructure, rather than dispersing resources thinly across other types of health providers or programs.[3,4] By focusing the resources on hospitals, Congress was addressing the risk of closures, particularly in light of the substantial reductions in federal Medicaid spending slated in the next few years, and ensuring that rural Americans continue to have a reliable, local point of entry to the healthcare system.

Therefore, we urge CMS to prioritize direct support for rural hospitals and providers. Specifically, the agency should lift the 15% funding cap it imposed on provider payments and the 20% cap it imposed on infrastructure and capital improvement funding for years two through five of the program. Further, CMS should allow for major building construction and renovations and equipment upgrades. These restrictions are not required by statute and hinder the fund's ability to achieve its intent to stabilize, modernize and sustain rural hospitals. For example, many rural hospitals were constructed over seven decades ago following the passage of the Hill-Burton Act of 1947, which provided grants and loans for the construction and modernization of hospitals and other healthcare facilities. Hospitals' ability to update their aging facilities to adapt to new medical technologies and safety protocols is limited by their very narrow, often negative financial margins. Lifting the infrastructure cap is also essential to prevent the emergence of a two-tier healthcare system in which rural Americans are forced to choose between receiving care in aging, under-resourced facilities that cannot keep pace with modern standards or leaving their communities altogether to access care elsewhere.

Additionally, CMS should work with Congress to allow states to revise their initial applications and provide a longer timeline to spend obligated funds. These actions would allow states greater flexibility to right-size projects and initiatives during the five-year funding program. States had less than two months to craft their applications, a massive task. Furthermore, they are required to spend obligated funds

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[2] https://academic.oup.com/healthaffairsscholar/advance-article/doi/10.1093/haschl/qxaf091/8120789; https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/; https://academic.oup.com/healthaffairsscholar/advance-article/doi/10.1093/haschl/qxaf091/8120789

[3] Bipartisan Policy Center. (Sep 2025). https://bipartisanpolicy.org/explainer/rural-health-transformation-program-notice-of-funding-opportunity/

[4] Kaiser Family Foundation. (Aug 2025). https://www.kff.org/medicaid/a-closer-look-at-the-50-billion-rural-health-fund-in-the-new-reconciliation-law/

by the following budget year. For many states, these timelines are simply too short to create transformational change that meets the spirit of the program. Application revisions and a longer timeline would allow states to more thoughtfully craft health programs that are most applicable for their communities. It would also allow them to better learn from this first budget period the projects and initiatives that should be prioritized and expanded for years two through five.

As first-year funding continues to be distributed, we also urge CMS to publicly post, in a standard format, the funding information that states report. This would ensure that all stakeholders, including Congress, can accurately determine whether RHTP funding intended to support and sustain hospitals actually flows to them. We encourage the agency to be as detailed as possible when tracking and reporting the final destinations of these funds, given the complexity of the grant funding process. For example, once CMS approves states' applications, states can utilize a combination of subawards, subrecipients, pass-through entities, contractors and other procurement processes to expend federal funds. It is vital, therefore, that the *final* beneficiaries or awardees be publicly posted using appropriate and relevant categories. These categories may include, for example, hospitals, clinics, physicians, technology vendors, consulting organizations, school programs and state entities, such as departments of health and education.

We also reiterate our previous request and continue to urge CMS to ensure that states and the agency itself do not enact undue administrative barriers to hospitals' ability to receive the funds. Complex bureaucratic processes or excessive paperwork could delay or even prevent hospitals from getting the support they need to improve rural health care. Specifically, we urge CMS to:

- Remove any requirement that the agency itself review all public-facing documents and every application solicited through a state's proposal process.
- Clarify to the states that funding cannot be issued on a reimbursable model. That is, hospitals should not have to expend funds first and then be reimbursed by the RHTP through the state. Many rural hospitals and providers cannot front the costs of these projects.
- Clarify its guidance that federal funds cannot be held for more than three working days by fund recipients.[5] These restrictions and lack of clarity are particularly detrimental at a time when hospitals and rural communities need expeditious and consistent deployment of resources.
- Create technical assistance centers to enable rural providers to quickly apply for and access program funds. For example, these could be related to providing grant writing help for rural facilities and providing proposal templates to reduce variation across projects and states.

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[5] https://www.cms.gov/files/document/frequently-asked-questions-april-2026.pdf

Finally, we ask CMS to ensure that the RHTP funds received by hospitals are separately reported on the Medicare cost report. Specifically, the agency should create separate, specific lines in the "Other Income" section of worksheet G-3 of the cost report for hospitals to report funds received from the RHTP. Doing so would help enable consistent hospital reporting and avoid skewing cost and reimbursement analyses. We also urge CMS to provide clear instructions that RHTP funds should not offset expenses listed within the cost report.

We thank you for your consideration of our comments. Please contact me if you have questions, or feel free to have a member of your team contact Shannon Wu, AHA director of policy, at swu@aha.org or 202-626-2963.

Sincerely,

/s/

Molly Smith
Group Vice President
Public Policy

Cc:
Alina Czekai
Director of the Office of Rural Health Transformation, CMS