Federation of American Hospitals

Charlene K. MacDonald
President and CEO

August 5, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-10949
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Rural Health Transformation (RHT) Program Reporting; CMS-10949; OMB 0938-TBD; 91 Fed. Reg. 41039 (July 6, 2026)

Dear Administrator Oz:

The Federation of American Hospitals (FAH) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed information collection request for the Rural Health Transformation (RHT) Program Reporting requirements. FAH is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high quality, affordable care in urban and rural areas across 46 states, plus Washington, DC, and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children, and cancer services.

The RHT Program represents an important investment in strengthening access to care and improving health outcomes in rural communities. As CMS implements the program's reporting requirements, it is important that the collection of information supports meaningful program oversight and accountability while minimizing unnecessary administrative burden and providing States with clear, consistent expectations for reporting.

FAH appreciates CMS's consideration of the comments submitted during the initial comment period and the meaningful revisions reflected in the updated collection. We commend CMS for adding a more detailed subrecipient reporting structure, which will provide valuable visibility into how Rural Health Transformation Fund dollars flow through intermediaries to the providers and communities the program is intended to benefit. We also appreciate the addition of standardized fields for entity type and use of funds, which will improve the consistency and usability of the collected data.

Building on these improvements, FAH offers the following recommendations to further advance the transparency and oversight objectives we share with CMS. Two elements from our earlier comments remain unaddressed, and we respectfully offer them for CMS's consideration as it finalizes the collection. We also offer refinement of the subrecipient reporting structure informed by our members' early experience with state implementation.

Provider Identifiers in the Reporting Fields

FAH appreciates that the revised instrument replaces free-text entry with structured Entity Type and Use of Funds fields drawn from defined categories, however one element of that recommendation remains unaddressed. The revised template identifies entities by name and category only. It does not capture a CMS Certification Number

(CCN), a National Provider Identifier (NPI), or any other Medicare identifier for the facilities and providers that receive RHT funds.

Requiring a CCN for any recipient that holds one, and an NPI where a CCN does not apply, would enable compatibility with existing provider datasets and support cross-program analysis. Without a standard identifier, an RHT fund recipient cannot be reliably linked to the Medicare provider file or cross-referenced with other CMS data systems. Name-only identification is difficult to deduplicate and validate, particularly as the program scales to quarterly reporting across all fifty states and thousands of recipients.

FAH strongly recommends that CMS add CCN and NPI fields to the entity reporting template and design them into the web-based reporting tool from the outset, so that the data is analyzable and auditable from the first reporting cycle. The added burden on states and recipients would be minimal, as recipients already know their own identifiers, and the fields fit naturally within the structured, dropdown-driven format CMS has adopted.

Reporting Across the Full Funding Chain

The subrecipient reporting structure added in the revised collection is a meaningful improvement, and early state implementation demonstrates why this level of reporting is needed. States are already administering RHT funding opportunities through entities other than the state agency itself. New Hampshire, for example, issued its emergency medical services funding opportunity through the Foundation for Healthy Communities, a nonprofit intermediary. **FAH recommends that the reporting instrument capture funds flow at each level of the funding chain: the state agency, any intermediary or state-designated hub, the direct recipient and the facility or provider ultimately delivering the service.**

FAH also recommends that reporting captures the status of funds at each level, including amounts awarded, obligated, paid, expended and remaining, together with the award date, the project period and whether payments are made as advances, reimbursements, milestone payments, or performance-based payments. Reporting limited to expenditures alone does not show whether funds have actually reached the provider delivering care. The instrument should likewise distinguish the type of payment being made, such as a grant or subaward, a contract for services, a capital purchase, an incentive or workforce payment, or reimbursement for documented costs. Each of these elements fits within the structured, dropdown driven format that CMS has adopted, and the information is already maintained by the state agencies and intermediaries that would report it, keeping added burden minimal.

Finally, reporting on how funded initiatives will meet the program's sustainability requirement would help providers and communities assess the durability of funded projects as they consider future applications.

Public Reporting and a Public-Facing Portal

In the materials accompanying the 60-day notice, CMS's Supporting Statement indicated that assurances of confidentiality would not be provided to respondents and that the information collected was "intended to be publicly available upon request." The revised Supporting Statement now states that "the results of this collection will not be published." **FAH respectfully urges CMS to reconsider this change and to ensure that the public has full visibility to the amount of funds received by each recipient.**

Routine public reporting would reinforce the Administration's stewardship of taxpayer dollars, give Congress, rural communities, and the public a clear line of sight into how this historic $50 billion investment is supporting rural health transformation, allow rural hospitals and providers to learn from initiatives in peer states, and create a natural mechanism for identifying best practices and detecting potential fraud, waste, or abuse. The provider identifiers described above would make such public reporting more accurate and more useful.

FAH urges CMS to develop a public-facing website that allows users to view and download non-sensitive RHT reporting data across all participating states, including state-level summaries of approved initiatives, Use of Funds data showing dollars expended by initiative, Use of Funds category and recipient category. Building this functionality into the MDCT tool from the outset would be substantially less expensive and less burdensome than constructing a separate public-reporting system later.

Conclusion

The PRA approval process and the parallel development of the CMCS-MDCT reporting tool together represent a narrow window in which CMS can build provider identification and public-facing transparency into the RHT Program by design rather than by retrofit. FAH appreciates the progress reflected in the revised collection, particularly on downstream reporting, and urges CMS to take advantage of this window to incorporate provider identification and public-facing transparency into the program from the outset.

Finally, hospitals provide the comprehensive services, clinical expertise, and care coordination that rural communities depend upon. CMS should ensure that Rural Health Transformation Program resources are prioritized to support hospitals and the patients they serve. To strengthen the transparency and effectiveness of the program, CMS should remove unnecessary funding caps on provider payments and infrastructure investments, work with Congress to provide states greater flexibility to modify approved projects and spend obligated funds, and establish dedicated Medicare cost report lines for RHTP payments. Together, these changes would enhance accountability, facilitate consistent program evaluation, and help ensure the program achieves its intended impact for rural communities.

We appreciate CMS's consideration of these comments and look forward to continued engagement on implementation of the RHT Program. If you have any questions, please reach out to Alyssa Keefe, Senior Vice President and Head of Policy, at akeefe@fah.org.

Sincerely,

/S/
Charlene MacDonald
President and CEO