PUBLIC SUBMISSION

As of: 5/11/26, 6:47 AM
Received: May 08, 2026
Status: Draft
Tracking No. mox-3bf3-k6tz
Comments Due: May 11, 2026
Submission Type: API

Docket: CMS-2026-0991
CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

Comment On: CMS-2026-0991-0001
CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

Document: CMS-2026-0991-DRAFT-0012
Comment on CMS-2026-0991-0001

Submitter Information

Email: tara.morse@fssa.in.gov
Government Agency Type: State
Government Agency: Indiana

General Comment

In regard to the CMS-10949 (Rural Health Transformation (RHT) Program Reporting), we suggest the following changes for the reporting template's Use of Funds chart in order to facilitate data compilation and reporting for the RHTP grant:

If the form is approved, please consider removing the Recipient Name and Recipient Category columns due to some states have multiple hundreds of rows so that funding is rolled up by Initiative, by Use of Funds category (breakdown by Recipient can be shared if CMS requests as a follow-up)

PUBLIC SUBMISSION

As of: 3/20/26, 6:42 AM
Received: March 13, 2026
Status: Draft
Category: Individual
Tracking No. mmp-4m2s-ctc0
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0991
CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

Comment On: CMS-2026-0991-0001
CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

Document: CMS-2026-0991-DRAFT-0001
Comment on CMS-2026-0991-0001

Submitter Information

Name: David Rocha
Address:
San Antonio, TX, 78256
Email: drocha3408@outlook.com

General Comment

The health systems that have not scaled APIs need a push from the corporate side so that the regional health systems and local health systems will use FHIR at scale.

The IPAs in rural areas can be assessed by size: small IPAs, medium IPAs, and large IPAs.
The large IPAs and some of the medium IPAs corporate offices will most likely have the technical staff and resources.
However, the large IPAs and some of the medium IPAs' satellite offices in rural areas may not have such access to the latest tech improvements.
The small IPAs and some of the medium IPAs may not have that same access to upgrade infrastructure to FHIR APIs and FHIR terminology services.
But one of the important things to assess with health records systems is whether the EHRs, platforms, telehealth, population health, is being managed by the value added resellers (VARs) instead of the vendors.
The third party technical staff need assistance and education on how to upgrade infrastructure to align with AI agent innovation.
CMS needs to assess if the value added resellers (VARs) and other intermediaries/delegated entities have access to the SQL data.

SQL on FHIR needs to scale for rural health.
The SQL on FHIR community could be useful to see how the data can transform for better analytics and real time reporting.

On the insurance side, there are issues when the TPAs and delegated entities (i.e. first tier, downstream

and related entities) have not collectively moved to FHIR APIs.
Rural Medicare beneficiaries will have difficulties when their Medicare Advantage HMO policy is delegated out to delegated entities.
Rural commercial beneficiaries will have difficulties when the TPAs and delegated entities have not moved to FHIR at scale.
The rural Medicaid beneficiaries will have difficulties in the remaining 15 states do not have live FHIR API endpoints in productions.

Possible KPIs could include:
• % of rural providers connected to TEFCA (small IPAs, medium IPAs, large IPAs, health systems, hospitals, allied health, post acute care, behavioral health)
• Average time to retrieve medical history from another provider
• % of rural health clinics connected to state HIE and TEFCA
• % of referrals leaving rural region
• % of reporting based on standards based exchange
• Time to detect care gaps

PUBLIC SUBMISSION

As of: 4/3/26, 12:30 PM
Received: March 31, 2026
Status: Draft
Category: Individual
Tracking No. mne-5koj-ebwp
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0991
CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

Comment On: CMS-2026-0991-0001
CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

Document: CMS-2026-0991-DRAFT-0002
Comment on CMS-2026-0991-0001

Submitter Information

Name: David Rocha
Address:
San Antonio, TX, 78256
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General Comment

Rural health transformation reporting needs to use FHIR API based data exchange from rural providers, rural organizations, and allied health entities.
MACs, RACs, UPICs, SMRCs, and QIOs also need to align to standards-based APIs collectively at scale and FHIR terminology services at scale to ameliorate the reporting data for program integrity and quality monitoring.

PUBLIC SUBMISSION

As of: 4/3/26, 12:32 PM
Received: March 31, 2026
Status: Draft
Category: Individual
Tracking No. mne-we7h-yqfk
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0991
CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

Comment On: CMS-2026-0991-0001
CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

Document: CMS-2026-0991-DRAFT-0003
Comment on CMS-2026-0991-0001

Submitter Information

Name: David Rocha
Address:
San Antonio, TX, 78256
Email: drocha3408@outlook.com

General Comment

CMS needs to move the healthcare claims attachments standards to FHIR APIs to avoid fragmented rural reporting infrastructure.
CMS asked for FHIR APIs for clinical data and quality, but CDA and X12 for healthcare claims attachments. This dichotomy will not move innovation to use FHIR APIs at scale across the healthcare ecosystem, including for rural healthcare. Rural transformation reporting needs to prioritize streamlined reporting via standards-based APIs (such as FHIR APIs) to move the healthcare industry forward.

PUBLIC SUBMISSION

As of: 4/3/26, 12:32 PM
Received: March 31, 2026
Status: Draft
Category: Individual
Tracking No. mnf-1xx5-92qn
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0991
CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

Comment On: CMS-2026-0991-0001
CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

Document: CMS-2026-0991-DRAFT-0004
Comment on CMS-2026-0991-0001

Submitter Information

Name: David Rocha
Address:
San Antonio, TX, 78256
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General Comment

Federal interoperability policy will continue to fragment when one agency promotes FHIR APIs and the other still clings to CDA and X12.
Healthcare should not claim AI readiness when attachment and document workflows are still dependent on PDFs, X12, and CDA.

PUBLIC SUBMISSION

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Tracking No. mnl-ya5g-0gmd
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0991
CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

Comment On: CMS-2026-0991-0001
CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

Document: CMS-2026-0991-DRAFT-0005
Comment on CMS-2026-0991-0001

Submitter Information

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Stony Brook, NY, 11790
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Phone: 6319812663

General Comment

The RHT Program's performance-based funding model depends entirely on the integrity of the data states submit. If the underlying clinical activity data contains coding variability — two rural providers billing differently for identical services — then milestone tracking, outcome measurement, and workload scoring become unreliable. Performance differentials between states may reflect documentation habits rather than actual care delivery differences.

I have developed a system that eliminates this variability at the source. Codes are generated deterministically from claim data — no provider discretion, no interpretation, no inconsistency. Identical services produce identical codes, regardless of state, facility, or clinician. This means the performance and evaluation metrics CMS will rely upon to recalculate each state's technical score and workload funding will reflect reality — not coding artifact.

The system is complete, fully tested, and carries no licensing burden to states or CMS. Rural communities deserve measurement systems as rigorous as the investments being made in them. I am available to discuss further.

Nakul Karkare MD
https://www.newyorkhipknee.com/
https://www.cortho.org

PUBLIC SUBMISSION

As of: 4/17/26, 11:47 AM
Received: April 13, 2026
Status: Draft
Category: Individual
Tracking No. mnx-9888-5zkt
Comments Due: May 11, 2026
Submission Type: Web

Docket: CMS-2026-0991
CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

Comment On: CMS-2026-0991-0001
CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

Document: CMS-2026-0991-DRAFT-0006
Comment on CMS-2026-0991-0001

Submitter Information

Name: David Rocha
Address:
San Antonio, TX, 78256
Email: drocha3408@outlook.com

General Comment

Clinician and administrative engagement in standards development organizations such as the creation of new value sets, reference sets, standards profiles, implementation guides, technical specifications, and ongoing workgroup committee participation, should count as improvement activities in Rural Health Transformation Program reporting. Clinicians are beneficial for the creation of standards development for existing and new use cases in standards development.

PUBLIC SUBMISSION

As of: 4/24/26, 8:32 AM
Received: April 23, 2026
Status: Draft
Tracking No. mob-kmg5-rloe
Comments Due: May 11, 2026
Submission Type: API

Docket: CMS-2026-0991
CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

Comment On: CMS-2026-0991-0001
CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

Document: CMS-2026-0991-DRAFT-0007
Comment on CMS-2026-0991-0001

Submitter Information

Name: Dominick Esposito
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Highlands Ranch, CO, 80126
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General Comment

Thank you for the opportunity to comment on this data collection effort for the CMS Rural Health Transformation Program. CMS efforts to reduce the burden of state agencies in reporting data to support programmatic objectives are apparent. We offer the following additional thoughts for CMS to consider.
- State participants would benefit from a consistent and easy-to-use data submission format, preferably with a centralized data submission hub, that is easy to learn for new employees who might join state agencies during the life of the program.
- CMS may minimize its own burden by providing states with streamlined reporting instructions, including expectations of the level of detail for quantitative and qualitative information (if applicable).
- States might benefit from a detailed understanding of how CMS will use the information that is collected to measure progress and recalculate their scores that determine annual funding levels. Some states may also require in-depth review of the CMS scoring rubric in one-on-one meetings.
- State engagement in reporting might be higher if some of the reported metrics or information were tied to state-specific activities, offering states the opportunity to report on their individual successes.
- CMS can also support states by providing ongoing support to answer questions about data submissions, including providing answers to frequently asked questions, and offering timely review of state-submitted information so that states can quickly turn around any necessary revisions.
These factors may help CMS:
- Compare data across states as it tries to understand lessons learned and the extent to which states meet collective program objectives.
- Reduce overall burden to states, minimizing their time on reporting and enabling states to focus more effort on program operations, and support on time reporting by states.

Disclosures:

Rural Health Transformation Program Reporting (CMS-10949; OMB 0938-TBD)
This is a new collection of information request that has not been approved by the Office of Management and Budget (OMB). At this time the OMB control number has yet to be determined. OMB will issue the control number upon their approval of the 30-day collection of information request.

- This is a draft document that is subject to change.
- The draft template is not approved by OMB.
- Interested parties should refer to the Federal Register for dates/instructions on submitting comments specific to the draft template or any of parts of this collection of information request.
- CMS is in the process of obtaining OMB's approval of the template under the Paperwork Reduction Act (PRA) process.
- CMS will inform when the final template has been approved by OMB.

RHT Program Annual Reporting Template

The purpose of this workbook is to facilitate States' annual reporting requirements as recipients of RHT Program grant funds. Please do not change the formatting of the Excel other than adjusting row height or column width if needed. Individualized State reporting templates pre-populated with initiative and state policy action commitment data will be provided after this template receives Paperwork Reduction Act approval. The

Initiative Tabs: Forms for the States to fill out that include initiative names, numbers, narratives, number of people served, metrics, checkpoints, and attachment names. There will be a tab for each State initiative with the initiative name and number pre-populated. For each metric declared on the State's application, they should provide the most recent available value as well as the date for which the reported value is current (for example, a metric pertaining to data that is reported to the State annually would only be updated once per year with the analysis date listed). Checkpoints within a stage can be completed in any order, but progress towards the next stage will not be scored until every checkpoint within the current stage is complete. Every checkpoint requires evidentiary documentation. The evidentiary documentation for each checkpoint should be compiled into a Master Initiative Attachment PDF and labeled in the PDF by

State Policy Action Commitments Tab: Form for the States to fill out regarding the current status of their State policy action commitments. States may only report progress on policy commitments identified in their applications and for which they received credit; therefore, only those specific rows will be provided to populate for each State. For State policy action commitments that States are attesting to a change in status, it is required to include supporting evidence, most commonly provided in the form of a link

Use of Funds Tab: Form for the States to help track their spending across initiatives, recipients, and use of funds categories. A single payment may be written as one line with the full payment if it can be allocated to a single initiative, recipient, and use of funds category. If the State determines that a given payment ought to be assigned to more than one initiative, was divided among multiple recipients, and/or applies to multiple use of funds categories, the State should divide the total into multiple lines with an appropriate funding amount assigned to each. Each row should also include an

Sustainability and Highlights Tab: Form for the States to share success stories and updates to their sustainability plans based on the implementation of the RHT Program.

Draft

#	Initiative Name
1	

Narrative

Number of People Served

Please provide the number of people served

Metrics

#	Metric	Current Value
1		
2		
3		
4		

Stage 0 – Planning

Checkpoint		Yes/No	Attachment(s)
0.1	Establish governance	No	
0.2	Submit project plan to CMS	No	

Stage 1 – Project Preparation

Checkpoint		Yes/No	Attachment(s)
1.1	CMS approval of project plan	No	
1.2	Launch initiative	No	

Stage 2 – Early Implementation

Checkpoint		Yes/No	Attachment(s)
2.1	Continue initiative activities	No	
2.2	Achieve at least one milestone	No	
2.3	Establish metric reporting methodology	No	
2.4	Submit updated project plan to CMS	No	

Stage 3 – Midway Implementation

Checkpoint		Yes/No	Attachment(s)
3.1	CMS approval of updated project plan	No	
3.2	Complete Q2 2028 milestones	No	
3.3	Report initial metric progress to CMS	No	

Stage 4 – Preparation for Completion

Checkpoint		Yes/No	Attachment(s)
4.1	Share final deliverables plan with CMS	No	
4.2	CMS approval of final deliverables plan	No	
4.3	Complete post-program planning	No	

Stage 5 – Full Implementation

Checkpoint		Yes/No	Attachment(s)
5.1	Submit final deliverables to CMS	No	
5.2	Complete all 2030 milestones	No	
5.3	Report updated metric progress to CMS	No	

As of Date

Draft

Score Factor	Workload Funding Score Factor Criterion
B. 2.	Presidential Fitness Test
B. 3.	SNAP Food Restriction Waiver Policy
B. 4.	Nutrition Continuing Medical Education
C. 3.	Overall CON Score
	CON - Behavioral Outpatient
	CON - Medical Outpatient
	CON - Behavioral Inpatient
	CON - Imaging
	CON - Medical Inpatient
	CON - Day Services
	CON - Long-term Care Facilities
	CON - Ancillaries
	CON - Other
D. 2.	Physician - Medical Licensure Compact
	Nurse - Nurse Licensure Compact
	EMS - EMS Compact
	Psychology - PSYPACT
	Physician Assistant - PA Compact
D. 3.	PA - Scope of Practice
	NP - Scope of Practice
	Pharmacist - Overall Score
	Pharmacist - Drug Administration
	Pharmacist - Lab Testing
	Pharmacist - Independent Prescribing
	Dental Hygienist - Overall Score
	Dental Hygienist - Dental Hygiene Diagnosis
	Dental Hygienist - Prescriptive Authority
	Dental Hygienist - Local Anesthesia
	Dental Hygienist - Supervision of Dental Assistants
	Dental Hygienist - Direct Medicaid Reimbursement
	Dental Hygienist - Dental Hygiene Treatment Planning
	Dental Hygienist - Provision of Sealants
	Dental Hygienist - Direct Access to Prophylaxis
E. 3.	Short-term, limited-duration insurance (STLDI)
F. 1.	Medicaid Payment for at Least One Form of Live Video
	Medicaid Payment for Store and Forward
	Medicaid Payment for Remote Patient Monitoring (RPM)
	In-State Licensing Requirement Exception
	Telehealth License/Registration Process (including special licenses)

Commitment	Current Status

Supporting Evidence

Optional Comments/Notes

Draft

ID	Spent Funds ($)

Description

Initiative #	Use of Funds	Recipient Name

Recipient Category

Draft

Success Stories

Please share success stories that you want to highlight as result of your State's implementation of the RHT Program.

Sustainability Planning

What are the most significant updates or changes to your sustainability plan based on the past year's experiences, successes, and challenges?

Disclosures:

Rural Health Transformation Program Reporting (CMS-10949; OMB 0938-TBD)
This is a new collection of information request that has not been approved by the Office of Management and Budget (OMB). At this time the OMB control number has yet to be determined. OMB will issue the control number upon their approval of the 30-day collection of information request.

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- Respondents should not complete/submit the draft template to CMS.

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Initiative Tabs: Forms for the States to fill out that include initiative names, numbers, narratives, number of people served, metrics, checkpoints, and attachment names. There will be a tab for each State initiative with the initiative name and number pre-populated. For each metric declared on the State's application, they should provide the most recent available value as well as the date for which the reported value is current (for example, a metric pertaining to data that is reported to the State annually would only be updated once per year with the analysis date listed). Checkpoints within a stage can be completed in any order, but progress towards the next stage will not be scored until every checkpoint within the current stage is complete. Every checkpoint requires evidentiary documentation. The evidentiary documentation for each checkpoint should be compiled into a Master Initiative Attachments PDF and labeled in the PDF by initiative and stage/checkpoint number. Within the checkpoint attachments column in this reporting template, please include the section label of the evidentiary

State Policy Action Commitments Tab: Form for the States to fill out regarding the current status of their State policy action commitments. States may only report progress on policy commitments identified in their applications and for which they received credit; therefore, only those specific rows will be provided to populate for each State. For State policy action commitments that States are attesting to a change in status, it is required to include supporting evidence, most commonly provided in the form of a link to a State register, press release, or similar. The current status column will have dropdown options available in the final reporting template

Use of Funds Tab: Form for the States to help track their spending across initiatives, recipients, and use of funds categories. A single payment may be written as one line with the full payment if it can be allocated to a single initiative, recipient, and use of funds category. If the State determines that a given payment ought to be assigned to more than one initiative, was divided among multiple recipients, and/or applies to multiple use of funds categories, the State should divide the total into multiple lines with an appropriate funding amount assigned to each. Each row should also include an ascending payment ID number, a description of the payment, and the type of recipient category. The recipient categories will be available as a dropdown in the final reporting template. More

Sustainability and Highlights Tab: Form for the States to share success stories and updates to their sustainability plans based on the implementation of the RHT Program.


DRAFT


DRAFT

Draft

#	Initiative Name
1	

Narrative

Number of People Served

Please provide the number of people served

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Stage 0 – Planning

	Checkpoint	Yes/No	Attachr
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Stage 1 – Project Preparation

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Stage 2 – Early Implementation

	Checkpoint	Yes/No	Attachr
2.1	Continue initiative activities	No	
2.2	Achieve at least one milestone	No	
2.3	Establish metric reporting methodology	No	
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Stage 3 – Midway Implementation

	Checkpoint	Yes/No	Attachr
3.1	CMS approval of updated project plan	No	
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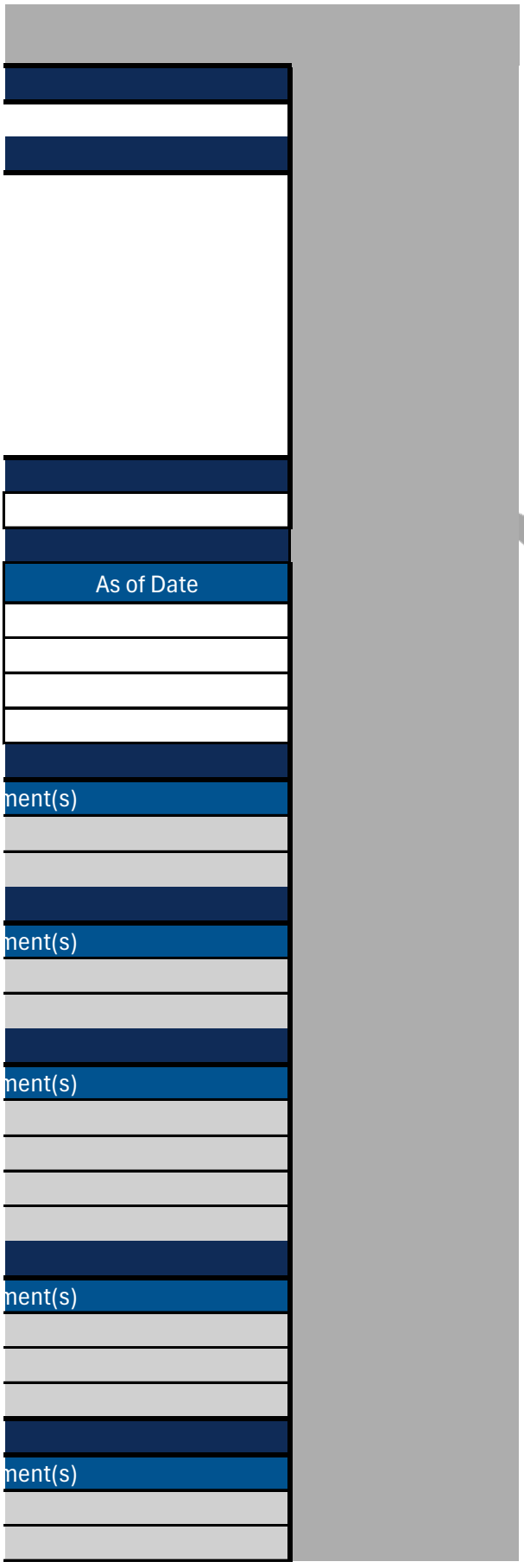
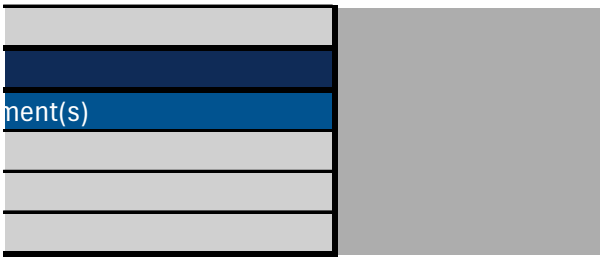
3.3	Report initial metric progress to CMS	No	

Stage 4 – Preparation for Completion

	Checkpoint	Yes/No	Attachr
4.1	Share final deliverables plan with CMS	No	
4.2	CMS approval of final deliverables plan	No	

4.3	Complete post-program planning	No	
Stage 5 – Full Implementation			
Checkpoint		Yes/No	Attachr
5.1	Submit final deliverables to CMS	No	
5.2	Complete all 2030 milestones	No	
5.3	Report updated metric progress to CMS	No	





Draft

Score Factor	Workload Funding Score Factor Criterion
B.2.	Presidential Fitness Test
B.3.	SNAP Food Restriction Waiver Policy
B.4.	Nutrition Continuing Medical Education
C.3.	Overall CON Score
	CON - Behavioral Outpatient
	CON - Medical Outpatient
	CON - Behavioral Inpatient
	CON - Imaging
	CON - Medical Inpatient
	CON - Day Services
	CON - Long-term Care Facilities
	CON - Ancillaries
	CON - Other
D.2.	Physician - Medical Licensure Compact
	Nurse - Nurse Licensure Compact
	EMS - EMS Compact
	Psychology - PSYPACT
	Physician Assistant - PA Compact
D.3.	PA - Scope of Practice
	NP - Scope of Practice
	Pharmacist - Overall Score
	Pharmacist - Drug Administration
	Pharmacist - Lab Testing
	Pharmacist - Independent Prescribing
	Dental Hygienist - Overall Score
	Dental Hygienist - Dental Hygiene Diagnosis
	Dental Hygienist - Prescriptive Authority
	Dental Hygienist - Local Anesthesia
	Dental Hygienist - Supervision of Dental Assistants
	Dental Hygienist - Direct Medicaid Reimbursement
	Dental Hygienist - Dental Hygiene Treatment Planning
	Dental Hygienist - Provision of Sealants
	Dental Hygienist - Direct Access to Prophylaxis
E.3.	Short-term, limited-duration insurance (STLDI)
F.1.	Medicaid Payment for at Least One Form of Live Video
	Medicaid Payment for Store and Forward
	Medicaid Payment for Remote Patient Monitoring (RPM)
	In-State Licensing Requirement Exception
	Telehealth License/Registration Process (including special licenses)

Commitment	Current Status	Supporting Evidence

Optional Comments/Notes

Draft

ID	Spent Funds ($)

Description	Initiative #

Use of Funds	Recipient Name

Recipient Category

Draft

Success Stories
Please share success stories that you want to highlight as result of your State's implementation of the RHT Program.

Sustainability Planning
What are the most significant updates or changes to your sustainability plan based on the past year's experiences, successes, and challenges?

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board | 50 F Street NW | Washington, DC 20001 | (202) 507-4070 | (202) 507-4071 fax

May 7, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted via regulations.gov

Re: Agency Information Collection Activities: Proposed Collection; Comment Request (CMS-10949)

Dear Administrator Oz:

On behalf of the Centers for Medicare and Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG), we write to respond to the CMS notice for comment regarding reporting for the Rural Health Transformation (RHT) Program. We appreciate CMS' efforts to improve access to quality healthcare in rural and underserved areas and recognize the program's importance to advance healthcare across Indian Country. For the RHT Program to be effective in Indian Country, it is essential that CMS' required reporting provide transparency and meaningful insight into how program funds are allocated to and benefit Tribes, Tribal organizations, Tribal consortia, and Urban Indian Organizations (UIOs).

Tribal Specific Reporting Measures

TTAG strongly recommends that CMS require states to include Tribal specific data elements, including but not limited to:

- The number of Tribal Nations, Tribal organizations, Tribal consortia, and UIOs located within the State;
- The number of rurally designated areas covered by Tribal health systems located within the State;
- The number of Tribal Nations, Tribal organizations, Tribal consortia, and UIOs that applied for RHT Program funding;
- The number of Tribal applicants that received awards;

- How each Tribal recipient is formally classified by the State for purposes of the RHT Program (e.g., awardee, grantee, sub recipient, contractor, or other designation):
- The amount of baseline and performance based workload funding awarded to each Tribal entity; and
- Changes in funding allocations to Tribal awardees across current and future budget periods.

These measures are necessary to ensure CMS can accurately assess program reach and impact in Tribal communities and to support CMS' recalculation of state technical scores and workload funding amounts as described in the proposed information collection. CMS should utilize Tribal recipient classification data in particular to identify when Tribes, Tribal organizations, and UIOs are limited in meaningful participation in the program.

Quarterly Reporting Considerations

Given the quarterly reporting requirement, TTAG recommends that CMS use these reports to identify late, incomplete, or missing submissions that affect Tribal participation or funding flow. CMS should proactively engage with states to address reporting challenges early and conduct targeted outreach where deficiencies may increase administrative or reporting burden on Tribes, Tribal organizations, Tribal consortia, and Urban Indian Organizations.

CMS should also instruct states to ensure that quarterly reporting processes and timelines do not inadvertently shift administrative burden onto Tribal partners, particularly where Tribes are required to provide data to states without corresponding technical assistance or support. CMS TTAG encourages CMS to adopt reporting requirements which are the least burdensome on subgrantees which will allow the majority of funds to be appropriately directed to programmatic activities, and to align reporting metrics with existing reporting requirements and metrics so grantees and subgrantees do not need to invest in new reporting tools and process which will ultimately detract from the mission of the RHT Program.

Annual Reporting and Tribal Engagement

TTAG further urges CMS to require states, through the annual reporting process, to document Tribal engagement and consultation efforts conducted during the RHT Program grant period. At a minimum, annual reports should describe:

- How states engaged with Tribal governments, Tribal organizations, and UIOs during the program planning and implementation phases;
- How input and feedback provided by Tribal governments, Tribal organizations, and UIOs are incorporated into states' final plans;
- Challenges identified by Tribal entities related to RHT Program participation and reporting; and
- Actions taken by states in response to concerns raised by Tribal and UIOs.

Throughout the development of the RHT Program, TTAG has consistently emphasized the importance of meaningful Tribal consultation to ensure RHT Program funding flows to Indian Country. Annual reporting provides CMS with a critical tool to evaluate whether States are meeting these expectations and honoring CMS's federal trust responsibility in the design and oversight of the RHT Program. TTAG further requests CMS program officers document Tribal and UIO engagement in state visit reports, consistent with Administrator Oz and Deputy Administrator Klomp's commitment to meet with Tribal leaders during state visits.

Conclusion

TTAG appreciates CMS's consideration of these recommendations and believes that incorporating Tribal specific reporting requirements into RHT Program reporting will strengthen program oversight, promote transparency, and improve outcomes for Tribal communities. In addition, TTAG requests that CMS annually share aggregate Tribal-specific data derived from state reports in support of TTAG's advisory role. We look forward to continued collaboration with CMS to ensure the RHT Program meaningfully advances healthcare access, quality, and outcomes in Indian Country.

Sincerely,

W. Ron Allen, CMS/TTAG Chair
Jamestown S'Klallam Tribe, Chairman/CEO

CC: Mark Cruz, Senior Advisor to the Secretary
Rachel Ryan Pederson, Acting Director, CMS Division of Tribal Affairs

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board | 50 F Street NW | Washington, DC 20001 | (202) 507-4070 | (202) 507-4071 fax

May 7, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted via regulations.gov

Re: Agency Information Collection Activities: Proposed Collection; Comment Request (CMS-10949)

Dear Administrator Oz:

On behalf of the Centers for Medicare and Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG), we write to respond to the CMS notice for comment regarding reporting for the Rural Health Transformation (RHT) Program. We appreciate CMS' efforts to improve access to quality healthcare in rural and underserved areas and recognize the program's importance to advance healthcare across Indian Country. For the RHT Program to be effective in Indian Country, it is essential that CMS' required reporting provide transparency and meaningful insight into how program funds are allocated to and benefit Tribes, Tribal organizations, Tribal consortia, and Urban Indian Organizations (UIOs).

Tribal Specific Reporting Measures

TTAG strongly recommends that CMS require states to include Tribal specific data elements, including but not limited to:

- The number of Tribal Nations, Tribal organizations, Tribal consortia, and UIOs located within the State;
- The number of rurally designated areas covered by Tribal health systems located within the State;
- The number of Tribal Nations, Tribal organizations, Tribal consortia, and UIOs that applied for RHT Program funding;
- The number of Tribal applicants that received awards;

- How each Tribal recipient is formally classified by the State for purposes of the RHT Program (e.g., awardee, grantee, sub recipient, contractor, or other designation):
- The amount of baseline and performance based workload funding awarded to each Tribal entity; and
- Changes in funding allocations to Tribal awardees across current and future budget periods.

These measures are necessary to ensure CMS can accurately assess program reach and impact in Tribal communities and to support CMS' recalculation of state technical scores and workload funding amounts as described in the proposed information collection. CMS should utilize Tribal recipient classification data in particular to identify when Tribes, Tribal organizations, and UIOs are limited in meaningful participation in the program.

Quarterly Reporting Considerations

Given the quarterly reporting requirement, TTAG recommends that CMS use these reports to identify late, incomplete, or missing submissions that affect Tribal participation or funding flow. CMS should proactively engage with states to address reporting challenges early and conduct targeted outreach where deficiencies may increase administrative or reporting burden on Tribes, Tribal organizations, Tribal consortia, and Urban Indian Organizations.

CMS should also instruct states to ensure that quarterly reporting processes and timelines do not inadvertently shift administrative burden onto Tribal partners, particularly where Tribes are required to provide data to states without corresponding technical assistance or support. CMS TTAG encourages CMS to adopt reporting requirements which are the least burdensome on subgrantees which will allow the majority of funds to be appropriately directed to programmatic activities, and to align reporting metrics with existing reporting requirements and metrics so grantees and subgrantees do not need to invest in new reporting tools and process which will ultimately detract from the mission of the RHT Program.

Annual Reporting and Tribal Engagement

TTAG further urges CMS to require states, through the annual reporting process, to document Tribal engagement and consultation efforts conducted during the RHT Program grant period. At a minimum, annual reports should describe:

- How states engaged with Tribal governments, Tribal organizations, and UIOs during the program planning and implementation phases;
- How input and feedback provided by Tribal governments, Tribal organizations, and UIOs are incorporated into states' final plans;
- Challenges identified by Tribal entities related to RHT Program participation and reporting; and
- Actions taken by states in response to concerns raised by Tribal and UIOs.

Throughout the development of the RHT Program, TTAG has consistently emphasized the importance of meaningful Tribal consultation to ensure RHT Program funding flows to Indian Country. Annual reporting provides CMS with a critical tool to evaluate whether States are meeting these expectations and honoring CMS's federal trust responsibility in the design and oversight of the RHT Program. TTAG further requests CMS program officers document Tribal and UIO engagement in state visit reports, consistent with Administrator Oz and Deputy Administrator Klomp's commitment to meet with Tribal leaders during state visits.

Conclusion

TTAG appreciates CMS's consideration of these recommendations and believes that incorporating Tribal specific reporting requirements into RHT Program reporting will strengthen program oversight, promote transparency, and improve outcomes for Tribal communities. In addition, TTAG requests that CMS annually share aggregate Tribal-specific data derived from state reports in support of TTAG's advisory role. We look forward to continued collaboration with CMS to ensure the RHT Program meaningfully advances healthcare access, quality, and outcomes in Indian Country.

Sincerely,

W. Ron Allen, CMS/TTAG Chair
Jamestown S'Klallam Tribe, Chairman/CEO

CC: Mark Cruz, Senior Advisor to the Secretary
Rachel Ryan Pederson, Acting Director, CMS Division of Tribal Affairs

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Comment On: CMS-2026-0991-0001
CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

Document: CMS-2026-0991-DRAFT-0011
Comment on CMS-2026-0991-0001

Submitter Information

Email: tara.morse@fssa.in.gov
Government Agency Type: State
Government Agency: Indiana

General Comment

In regard to the CMS-10949 (Rural Health Transformation (RHT) Program Reporting), we suggest the following changes for the reporting template's Use of Funds chart in order to facilitate data compilation and reporting for the RHTP grant:

Please consider allowing states the flexibility to use their own data reporting file as long as it clearly shows the total funding by Use of Funds category

Federation of American Hospitals

Charlene K. MacDonald
President and CEO

May 11, 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

Dear Administrator Oz:

The Federation of American Hospitals (FAH) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed Rural Health Transformation (RHT) Program reporting requirements.

FAH represents more than 1,000 leading tax-paying hospitals and health systems throughout the United States, including many facilities serving rural communities. We strongly support the Administration's efforts to improve healthcare access and outcomes in rural America and appreciate CMS's recognition that states require flexibility to design initiatives that meet the unique needs of their rural populations.

At the same time, given the scale of this investment and the importance of ensuring transparency, accountability, and effective stewardship of taxpayer dollars, FAH encourages CMS to structure the reporting requirements so that data can be consistently collected, analyzed, and compared across states—and made meaningfully available to the public. As CMS finalizes the reporting instrument and develops the web-based reporting tool, these early design decisions will help ensure that stakeholders, Congress, rural communities, and the public have a clear understanding of how this historic $50 billion investment is supporting rural health transformation over the next five years. FAH offers the following comments for consideration as the agency moves forward in this important endeavor.

Transparency and Standardization in Reporting

To improve transparency and reduce administrative burden for both states and CMS, FAH recommends that CMS establish a set of standardized reporting definitions and structured response options for the core fields on the Use of Funds tab and across the reporting instrument. Specifically, CMS should require dropdown selections from a defined, CMS-published taxonomy for: (1) Use of Funds category; (2) Recipient Category (with sufficient granularity to distinguish, for example, rural hospitals from academic medical centers, large multi-state health systems, state agencies, contractors, and community-based organizations); (3) Initiative type; (4) Payment purpose; and (5) CMS Certification Number (CCN) for any recipient that holds one, enabling compatibility with existing provider datasets and supporting cross-program analysis. Free-text description fields should remain available alongside these structured fields so that states can provide additional context, but the structured fields should be the basis for cross-state analysis and public reporting. Because CMS is currently building the dedicated web-based reporting tool through the CMCS-MDCT Team, FAH urges CMS to design these standardized fields into the tool from the outset rather than retrofit them later.

This type of structured reporting approach would improve the usability and reliability of collected data without undermining CMS's broader goal of allowing states flexibility in program implementation. Standardized fields for key

data elements would allow CMS to more efficiently compare information across states while still preserving states' ability to explain unique circumstances, innovative models, or region-specific challenges through narrative responses.

FAH believes this approach would significantly improve CMS's ability to conduct meaningful cross-state analysis, evaluate progress toward program goals, identify trends and best practices, detect potential fraud, waste, or abuse, and reduce the administrative burden associated with reviewing inconsistent or incomplete submissions. More structured reporting would also improve the long-term usability of the collected data and better position CMS to evaluate the effectiveness of the program over time.

Given the scale and complexity of the RHT Program, and the significant discretion afforded to states in designing initiatives and distributing funding, standardized reporting expectations will be important to promote consistency and comparability across states. Without such expectations, states may interpret reporting categories differently, apply inconsistent terminology, or report varying levels of specificity. As a result, CMS may face unnecessary challenges in evaluating how funds are being utilized and whether program goals are being achieved effectively across states.

Public Reporting and a CMS-Hosted Public-Facing Portal

As the Administration continues to prioritize transparency and accountability in federal programs, standardized reporting will be essential to ensuring that information from the RHT Program is meaningful, comparable, and accessible to rural communities, providers, policymakers, and researchers. The Supporting Statement accompanying this collection makes clear that "[a]ssurances of confidentiality will not be provided to respondents" and that the information being collected "is intended to be publicly available upon request." **FAH supports that posture and urges CMS to operationalize it through routine, structured public reporting rather than relying solely on document-by-document requests.**

Specifically, FAH recommends that CMS develop, in parallel with the dedicated web-based reporting tool currently under development by the CMCS-MDCT Team, a public-facing companion portal on CMS.gov that allows users to view and download non-sensitive RHT reporting data across all 50 states. At a minimum, the public-facing portal should include: (1) state-level summaries of approved initiatives, narratives; and (2) Use of Funds data showing dollars expended by initiative, Use of Funds category, recipient category, and (where the recipient is itself a public-facing entity) recipient name. Building this functionality into the MDCT tool from the outset will be substantially less expensive and less burdensome than constructing a separate public-reporting system later.

A public-facing portal would also reinforce the Administration's stewardship of taxpayer dollars, give Congress and the public a clear line of sight into how a $50 billion federal investment is supporting the program's objectives, 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.

Visibility Into Distribution of Funds

FAH believes CMS would benefit from greater visibility into how funds are ultimately distributed within states, particularly in states utilizing 'hub-and-spoke' models in which large health systems, academic medical centers, or other centralized entities receive and distribute substantial portions of RHT funding.

These partnership structures serve important operational or administrative functions and help facilitate statewide coordination in certain markets. However, absent more transparent reporting around downstream fund distribution, it may be difficult for CMS to assess whether funding is reaching the rural hospitals, providers, and communities primarily intended to benefit from the program.

In particular, FAH believes CMS should ensure that rural hospitals and providers with longstanding community partnerships are able to participate fully in these arrangements without disrupting existing relationships. We believe CMS intent is to strengthen existing partnerships while creating new partnerships where they did not exist, allowing for longer term sustainability and transformation of rural communities. Greater visibility into the flow of funds throughout these arrangements would help CMS better understand whether there are meaningful gaps in access to funding opportunities across provider types or geographic regions.

To ensure transparency and equitable access to funding opportunities, FAH encourages CMS to expand the Use of Funds tab to require states to report not only the primary recipient of each payment but also any

downstream subrecipients receiving a material share of those funds, along with each subrecipient's category and the amount passed through. Where a state, prime recipient, or convening entity acts as a pass-through to providers in a hub-and-spoke arrangement, the report should reflect both the initial payment and the downstream distribution. This level of reporting is consistent with standard federal grant subrecipient monitoring expectations, would close a meaningful visibility gap in the current draft, and would enable CMS to assess whether funds are reaching rural hospitals, providers, and communities directly, or whether geographic or provider-type gaps exist in funding distribution.

FAH believes visibility into these dynamics will be important not only from an oversight perspective, but also to help CMS identify whether there are structural barriers limiting participation among certain providers or communities. Understanding where funding is concentrated, and where it may not be reaching intended stakeholders, will help ensure the RHT Program supports broad-based rural transformation rather than reinforcing existing disparities in access to resources and infrastructure.

Conclusion

Finally, FAH encourages CMS to ensure that any final reporting requirements appropriately balance transparency and accountability with operational feasibility. Standardized reporting structures and definitions would not only improve data quality and oversight, but would also help reduce reporting burden on states and facilitate more timely and efficient CMS review and analysis. The PRA approval process and the parallel development of the CMCS-MDCT web-based reporting tool together represent a narrow window in which CMS can build standardization, downstream-recipient visibility, and public-facing transparency into the RHT Program by design rather than by retrofit. We urge CMS to take advantage of that window.

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

CENTER FOR REGULATORY ANALYSIS AND ENGAGEMENT

A Project of the Main Street Foundation

M E M O R A N D U M

To:	**Hon. Robert F. Kennedy, Jr., Secretary of Health and Human Services** **Hon. Mehmet Oz, MD, Administrator, Centers for Medicare and Medicaid Services**
From:	**Andrew Langer, President, Main Street Foundation**
Date:	**May 11, 2026**
Re:	**Comments on the Department of Health and Human Services Centers for Medicare and Medicaid Services Information Collection Request, "CMS-10949 (Rural Health Transformation (RHT) Program Reporting)," Docket #CMS-2026-0991, Fed. Reg. 2026-04745, Published March 11, 2026**

Below are comments of the Main Street Foundation's Center for Regulatory Analysis and Engagement (CRAE) in response to the Department of Health and Human Services Centers for Medicare and Medicaid Services Information Collection Request, "CMS-10949 (Rural Health Transformation (RHT) Program Reporting)," Docket #CMS-2026-0991, Fed. Reg. 2026-04745, published March 11, 2026.

CRAE is a project of the Main Street Foundation, a recently-formed non-profit, non-partisan 501(c)(3) research and education foundation. Our mission is to bring a disciplined, common-sense perspective to the regulatory process, one grounded in real-world experience, sound science, and rigorous economic analysis. We work to ensure that the costs, risks, and benefits of regulatory proposals are evaluated transparently and accurately, and that the voices, interests, and freedoms of Americans, particularly small businesses and working families, are meaningfully represented in regulatory debates. Above all, we focus on outcomes: regulations should address real problems, function effectively in practice, and improve conditions on the ground—not exacerbate the challenges they are intended to solve.

INTRODUCTION

The Center for Regulatory Analysis and Engagement ("CRAE") appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' proposed information collection associated with the Rural Health Transformation Program Reporting requirements. CRAE's mission is to promote disciplined, transparent, and economically realistic regulatory and

administrative frameworks that protect public interests while minimizing unnecessary burdens on productive activity and institutional capacity. CRAE has a longstanding interest in healthcare affordability, regulatory administrability, federal program accountability, and policies that strengthen the long-term economic and operational sustainability of rural communities and healthcare systems.

Stable and accessible rural healthcare systems play a critical role in maintaining the health, economic vitality, and long-term resilience of communities throughout the United States. Rural hospitals, clinics, physicians, emergency services providers, and healthcare support networks frequently serve as essential economic anchors within their communities while simultaneously providing indispensable healthcare access across large geographic areas. The operational health of rural healthcare systems affects not only patient outcomes, but also workforce participation, business investment, population retention, emergency preparedness, and the long-term viability of local economies that already face significant demographic and infrastructure challenges.

CRAE recognizes CMS's stated objective of improving healthcare access, quality, and outcomes through the Rural Health Transformation Program and acknowledges the importance of responsible stewardship of substantial federal investments in rural healthcare infrastructure and system modernization. Large-scale transformation initiatives can provide meaningful opportunities for states to improve healthcare coordination, strengthen provider capacity, and address persistent access challenges facing rural populations. At the same time, the effectiveness of such initiatives depends heavily on whether program administration, oversight structures, and reporting obligations remain appropriately calibrated to support operational success rather than unintentionally undermining it.

CRAE further recognizes that reporting and accountability mechanisms are necessary components of any major federal grant or transformation initiative. Effective oversight systems can help ensure transparency, program integrity, responsible expenditure of taxpayer resources, and informed evaluation of program performance. However, reporting systems function effectively only when they remain clear, predictable, proportional, and administratively manageable. Excessively complex or poorly coordinated reporting obligations can create significant operational burdens that consume administrative resources, divert personnel from healthcare delivery priorities, and reduce the flexibility necessary for states and providers to respond to evolving local healthcare conditions and operational realities.

CRAE is concerned that large-scale reporting systems, if not carefully limited and structured, can gradually evolve into expansive compliance architectures that impose substantial cumulative burdens on states, providers, and healthcare systems. Particularly within rural healthcare environments that already face staffing shortages, financial pressures, infrastructure limitations, and administrative capacity constraints, incremental reporting expansion can produce meaningful operational consequences. Reporting obligations that become excessively procedural, duplicative, or open-ended risk redirecting scarce financial and managerial resources away from patient care, workforce retention, infrastructure investment, service availability, and other core healthcare delivery priorities that the program itself is intended to strengthen.

Accordingly, CRAE encourages CMS to finalize a reporting framework that remains narrowly tailored to clearly defined program objectives, focused on meaningful performance outcomes, and attentive to the practical administrative realities facing rural healthcare systems and participating states. The final framework should prioritize transparency, predictability, interoperability, and efficient use of existing data systems while minimizing duplicative

reporting and unnecessary procedural complexity. CRAE further encourages CMS to maintain a technologically modernized, operationally flexible, and administratively disciplined reporting structure that preserves state flexibility, supports long-term program sustainability, and allows participating entities to devote maximum resources toward improving healthcare access and outcomes in rural communities.

EXECUTIVE SUMMARY

The Center for Regulatory Analysis and Engagement ("CRAE") supports responsible efforts to improve healthcare access, quality, and long-term system sustainability within rural communities. However, the long-term success of the Rural Health Transformation Program will depend not merely on the scale of federal funding, but on whether the program's reporting and oversight systems remain disciplined, transparent, outcome-oriented, and administratively manageable. Reporting frameworks materially shape operational behavior, resource allocation, and implementation priorities. Accordingly, CMS should ensure that the final reporting structure remains narrowly tailored, technologically efficient, minimally duplicative, and sufficiently flexible to accommodate the diverse operational realities facing rural healthcare systems and participating states.

Our comments make the following points:

- **CMS should ensure that all reporting requirements satisfy the Paperwork Reduction Act's practical utility and necessity standards and remain directly connected to meaningful program administration and evaluation objectives.**
- **The final framework should minimize duplicative reporting obligations by leveraging existing Medicare, Medicaid, grant-management, and healthcare reporting systems wherever possible.**
- **CMS should prioritize outcome-based performance measures focused on healthcare access, service availability, workforce stability, and long-term operational sustainability rather than excessive procedural or documentation-oriented metrics.**
- **Excessive administrative layering may divert scarce financial, managerial, and workforce resources away from patient care and healthcare delivery priorities within already constrained rural systems.**
- **CMS should provide greater transparency regarding technical scoring methodologies, evaluation criteria, weighting systems, and annual funding recalculation processes.**
- **Predictable and stable funding methodologies are essential to support long-term planning, infrastructure investment, and operational decision-making by participating states and rural healthcare systems.**
- **CMS should recognize that rural healthcare providers and state agencies often face significant administrative capacity limitations, staffing shortages, and infrastructure constraints that may complicate compliance with expansive reporting obligations.**
- **The final reporting framework should prioritize technological modernization, interoperability, standardized templates, and automated data integration to reduce administrative burden and improve reporting efficiency.**
- **CMS should avoid expanding substantive reporting obligations through subregulatory guidance, informal directives, or evolving administrative expectations that lack clear procedural safeguards.**

- **The final framework should preserve meaningful state flexibility and avoid imposing rigid federalized reporting structures that undermine locally tailored rural-health strategies and operational priorities.**
- **CMS should consider phased implementation mechanisms and transitional flexibility to allow participating states sufficient time to develop sustainable reporting infrastructure and operational systems.**
- **CMS should periodically reassess the continuing utility and operational value of reporting requirements to ensure that data collection remains proportional, relevant, and administratively justified over time.**

Durable rural-health policy depends on maintaining an appropriate balance between accountability and operational flexibility. Effective reporting systems should support transparency and responsible stewardship of taxpayer resources without creating unnecessary administrative burdens that undermine healthcare delivery capacity or discourage participation. CRAE therefore encourages CMS to finalize a reporting framework that remains proportionate, technologically modernized, operationally realistic, and attentive to the long-term sustainability of rural healthcare systems. A disciplined and administratively manageable framework will better position participating states and providers to devote maximum resources toward improving healthcare access, system resilience, and patient outcomes within rural communities.

I. CMS SHOULD ENSURE THAT THE REPORTING FRAMEWORK REMAINS NARROWLY TAILORED, PRACTICAL, AND CONSISTENT WITH PRA REQUIREMENTS

The Paperwork Reduction Act establishes an important statutory framework intended to ensure that federal information collections possess genuine practical utility and remain appropriately limited in scope. Congress enacted the PRA not merely to facilitate federal data collection, but also to protect states, regulated entities, and the public from unnecessary administrative burdens and inefficient reporting requirements. Particularly within large-scale healthcare initiatives involving substantial operational complexity and resource constraints, disciplined adherence to PRA principles remains essential to maintaining administratively sustainable and economically rational oversight structures that support, rather than undermine, program effectiveness.

CRAE recognizes that some level of reporting and performance evaluation is necessary to ensure responsible stewardship of taxpayer resources and effective administration of the Rural Health Transformation Program. However, reporting systems should function primarily as tools that facilitate program oversight, funding accountability, and operational evaluation rather than evolving into standalone compliance regimes. When reporting structures become excessively procedural or disconnected from core operational objectives, administrative systems can gradually prioritize documentation production over healthcare delivery outcomes. Effective oversight frameworks should therefore remain tightly connected to clearly defined programmatic goals and measurable operational functions.

Broad or ambiguously defined reporting expectations create substantial risk that administrative obligations will expand over time beyond the scope originally contemplated during program implementation. Particularly in large federal grant programs, open-ended reporting language can create incentives for incremental additions to reporting requirements through guidance documents, evolving administrative practices, or informal oversight expectations. This form of gradual reporting expansion can significantly increase compliance complexity even absent

formal rulemaking or statutory amendment. CMS should therefore ensure that all reporting obligations remain clearly defined, limited in scope, and directly connected to specific operational and evaluative objectives established at the outset of the program.

Excessive reporting obligations can impose meaningful operational costs on participating states and rural healthcare systems that already face substantial workforce, financial, and infrastructure constraints. Administrative personnel, healthcare executives, compliance staff, and program managers possess finite institutional capacity. Time and resources devoted to expansive reporting, documentation preparation, and compliance coordination are necessarily unavailable for patient care improvement, workforce recruitment, infrastructure modernization, service expansion, and other core healthcare priorities. Particularly in rural healthcare environments where administrative staffing capacity may already be limited, cumulative reporting burdens can create operational tradeoffs that materially affect healthcare delivery and long-term system sustainability.

Accordingly, CMS should require only information that is directly connected to funding administration, program evaluation, measurable operational outcomes, or clearly defined statutory objectives. Reporting systems are most effective when agencies can clearly articulate how each requested data element contributes to program oversight, funding determinations, performance measurement, or operational assessment. Information collections that lack a direct relationship to identifiable administrative or evaluative functions risk creating unnecessary burden without corresponding public benefit. A disciplined reporting structure that prioritizes measurable utility will better support both effective program management and compliance with the PRA's core statutory principles.

CMS should also avoid collecting speculative, excessively granular, or open-ended categories of information that lack clearly defined operational or evaluative value. In many federal reporting systems, agencies may be tempted to collect broad categories of data in anticipation of potential future analytical use. However, expansive data collection strategies can substantially increase administrative burden while generating information that is rarely utilized in meaningful decision-making processes. Reporting obligations should instead remain closely tied to concrete operational metrics, funding oversight responsibilities, and measurable program objectives. Limiting speculative data collection will help preserve administrative discipline and reduce unnecessary compliance complexity for participating states and providers.

For these reasons, CRAE encourages CMS to maintain a reporting architecture that remains disciplined, proportionate, clearly defined, and operationally focused throughout implementation of the Rural Health Transformation Program. The final framework should emphasize practical utility, transparency, predictability, and administrative efficiency while avoiding unnecessary procedural complexity and incremental reporting expansion. A carefully calibrated reporting structure will better position participating states and rural healthcare systems to devote resources toward healthcare delivery improvement rather than administrative compliance accumulation. Maintaining clear limits and disciplined oversight structures will ultimately strengthen both program accountability and long-term operational sustainability.

II. CMS SHOULD PRIORITIZE OUTCOME-ORIENTED PERFORMANCE MEASUREMENT RATHER THAN PROCEDURAL COMPLIANCE METRICS

The Rural Health Transformation Program should evaluate success primarily through measurable improvements in healthcare access, operational stability, patient outcomes, and long-term system resilience rather than through accumulation of procedural documentation and administrative activity. Transformation initiatives achieve meaningful public value when they improve the practical functioning of healthcare systems and strengthen service delivery capacity within underserved communities. Reporting frameworks that focus excessively on process compliance risk shifting institutional attention toward bureaucratic performance indicators that may bear only limited relationship to actual healthcare improvement. CMS should therefore ensure that program evaluation remains closely tied to substantive operational and patient-centered outcomes.

Process-heavy oversight structures can unintentionally incentivize administrative behavior that prioritizes documentation production over practical healthcare improvement. When reporting systems reward procedural completion, narrative submissions, meeting frequency, or internal compliance activity rather than operational performance, participating entities may devote disproportionate resources toward satisfying administrative expectations. Over time, such systems can create institutional incentives that favor bureaucratic expansion and compliance accumulation rather than innovation, service delivery, or healthcare accessibility. Particularly within resource-constrained rural healthcare environments, administrative incentives should remain carefully aligned with tangible healthcare outcomes and measurable improvements in system performance.

CRAE encourages CMS to prioritize outcome-oriented performance measures tied to healthcare access, provider availability, workforce retention, emergency care capacity, financial sustainability, service continuity, and long-term operational resilience. Metrics that evaluate whether rural communities experience improved healthcare availability and system stability are likely to provide more meaningful insight into program effectiveness than extensive process-oriented reporting requirements. CMS should also recognize that healthcare transformation frequently involves operational adaptation and localized problem-solving that may not fit neatly within rigid procedural reporting categories. A well-designed performance framework should therefore emphasize measurable healthcare impacts rather than excessive documentation of administrative activity.

CMS should further recognize that rural healthcare systems frequently operate under substantial workforce, infrastructure, geographic, and financial constraints that differ significantly from those facing larger urban healthcare systems. Many rural providers function with limited administrative staffing capacity while simultaneously managing persistent clinician shortages, aging infrastructure, transportation barriers, and challenging patient-access conditions. In these environments, excessive procedural reporting requirements may impose disproportionate burdens relative to available institutional resources. Reporting frameworks that require extensive administrative coordination or complex documentation systems may therefore reduce operational flexibility and strain already limited managerial and compliance capacity within participating rural healthcare organizations.

CRAE also cautions against adoption of rigid one-size-fits-all performance frameworks that fail to account for substantial variation among participating states, healthcare systems, geographic regions, and rural provider environments. Rural healthcare challenges differ significantly across

states based on demographics, geography, provider distribution, infrastructure capacity, workforce conditions, and local economic realities. Uniform reporting expectations that inadequately account for these differences may distort performance evaluations or unintentionally disadvantage states operating under more difficult structural conditions. CMS should therefore preserve sufficient flexibility within the evaluation framework to accommodate differing operational models, implementation strategies, and localized healthcare priorities among participating entities.

Long-term healthcare transformation should also be evaluated through sustainable operational improvements rather than short-term reporting outputs or temporary administrative benchmarks. Meaningful transformation within rural healthcare systems often requires gradual infrastructure development, workforce stabilization, provider recruitment, financial restructuring, and operational modernization efforts that may not produce immediate quantifiable results within early reporting periods. Evaluation systems that excessively prioritize short-term measurable activity may unintentionally discourage long-term strategic investment and sustainable operational planning. CMS should therefore adopt performance frameworks that recognize the importance of durable institutional improvement, system resilience, and long-term healthcare delivery capacity within rural communities.

Therefore, CRAE encourages CMS to prioritize flexible, outcome-focused evaluation structures that remain closely tied to measurable healthcare improvement and operational sustainability. Reporting systems should support accountability and informed program oversight without encouraging unnecessary procedural expansion or bureaucratic performance incentives disconnected from patient outcomes. A disciplined outcome-oriented framework will better position participating states and rural healthcare systems to focus institutional resources on strengthening healthcare access, improving operational resilience, and addressing the practical healthcare challenges facing rural communities. Maintaining flexibility and emphasizing substantive results will ultimately improve both program effectiveness and long-term system sustainability.

III. CMS SHOULD MINIMIZE DUPLICATIVE REPORTING AND REDUCE ADMINISTRATIVE LAYERING

Rural healthcare entities already operate within an extensive network of federal, state, and program-specific reporting environments that collectively impose significant administrative obligations on providers, healthcare systems, and state agencies. Hospitals, clinics, physicians, and healthcare administrators routinely navigate multiple reporting structures tied to reimbursement systems, grant programs, quality measurement initiatives, compliance oversight, and operational accountability requirements. Within many rural healthcare systems, administrative staffing capacity remains limited relative to the breadth of existing obligations. CMS should therefore ensure that implementation of the Rural Health Transformation Program does not unnecessarily compound an already substantial and increasingly complex reporting landscape.

Participating states and rural healthcare providers are already subject to overlapping Medicare, Medicaid, grant-management, quality-reporting, interoperability, and program-integrity reporting systems that frequently require submission of similar operational, financial, and performance information through multiple administrative channels. In many cases, healthcare entities must report related information to separate federal and state agencies using differing formats,

timelines, and evaluation methodologies. These fragmented reporting environments can create inefficiencies, increase compliance costs, and divert institutional resources toward repetitive administrative functions. The Rural Health Transformation Program should therefore be designed to complement, rather than further complicate, existing reporting and oversight systems.

Even relatively modest incremental reporting obligations can generate substantial cumulative administrative burdens when layered onto existing healthcare compliance systems. Additional reporting requirements often necessitate new staffing allocations, information technology modifications, internal review processes, consultant support, legal oversight, and ongoing administrative coordination efforts. Over time, the aggregate effect of multiple overlapping reporting systems can significantly increase operational costs and managerial complexity. Particularly within healthcare environments already facing financial pressures and workforce shortages, cumulative compliance expansion may materially affect institutional capacity, operational flexibility, and long-term sustainability. CMS should therefore carefully evaluate the aggregate administrative impact of all proposed reporting obligations.

Smaller rural healthcare systems and participating states may face especially disproportionate compliance burdens under expansive reporting frameworks. Large healthcare systems often possess dedicated compliance departments, data-management infrastructure, and administrative personnel capable of absorbing additional reporting obligations more easily than smaller organizations. By contrast, many rural hospitals, clinics, and state healthcare agencies operate with limited staffing capacity and fewer specialized administrative resources. As a result, even comparatively modest reporting expansions may impose greater operational strain on smaller entities. CMS should remain attentive to these asymmetrical compliance effects when designing and implementing reporting requirements under the Rural Health Transformation Program.

CRAE strongly encourages CMS to rely on existing Medicare, Medicaid, and federal grant-reporting systems wherever possible in order to minimize unnecessary duplication and administrative fragmentation. To the extent that relevant operational, financial, quality, or utilization information is already available through existing reporting channels, CMS should avoid requiring states or providers to resubmit substantially similar information through separate reporting mechanisms. Leveraging existing federal data infrastructure can improve administrative efficiency while reducing unnecessary compliance costs and duplicative data-management obligations. Greater integration across reporting systems would also help improve consistency, reduce reporting errors, and simplify long-term program administration.

CMS should also prioritize standardized reporting templates, interoperable reporting systems, and automated data-submission mechanisms capable of reducing administrative burden and improving reporting consistency across participating entities. Standardization can help reduce confusion regarding reporting expectations while minimizing time devoted to formatting, reconciliation, and procedural compliance. Interoperable systems and automated reporting tools may further reduce manual administrative work and improve operational efficiency for both participating states and CMS administrators. Particularly within rural healthcare systems that frequently operate under constrained staffing conditions, technological modernization and streamlined reporting infrastructure can play an important role in supporting sustainable program implementation.

CRAE further recommends that CMS limit reliance on open-ended narrative reporting requirements wherever possible and instead prioritize structured reporting formats tied to clearly

defined operational metrics and evaluation categories. Narrative submissions often require substantial staff time to prepare, review, revise, and interpret while simultaneously increasing subjectivity and inconsistency within the evaluation process. Excessively broad narrative reporting may also encourage incremental expansion of administrative expectations over time. Structured reporting systems that utilize standardized data elements, defined performance indicators, and clearly articulated submission requirements are generally more administratively manageable and operationally efficient for both reporting entities and federal administrators.

CRAE encourages CMS to minimize duplication, reduce administrative fragmentation, and maintain disciplined reporting structures throughout implementation of the Rural Health Transformation Program. Reporting systems should support effective oversight and responsible stewardship of federal resources without imposing unnecessary cumulative compliance burdens on participating states and rural healthcare providers. By emphasizing integration, standardization, interoperability, and administrative efficiency, CMS can strengthen program accountability while preserving operational flexibility and institutional capacity within rural healthcare systems. A carefully coordinated reporting framework will better support long-term healthcare improvement and sustainable program administration.

IV. CMS SHOULD PROVIDE GREATER TRANSPARENCY AND PREDICTABILITY REGARDING TECHNICAL SCORING AND FUNDING RECALCULATIONS

Transparent and clearly defined scoring systems are essential to fair, consistent, and predictable administration of large-scale federal transformation initiatives. Because the Rural Health Transformation Program ties ongoing funding allocations to technical scoring and annual performance evaluations, participating states require a clear understanding of how program performance will be assessed and how future funding determinations will be calculated. Ambiguity within scoring systems can create uncertainty regarding program expectations and operational priorities. CMS should therefore ensure that technical scoring methodologies and funding recalculation processes remain transparent, stable, and sufficiently defined to support reliable long-term program administration.

Predictability is particularly important within healthcare transformation initiatives that involve long-term operational planning, infrastructure investment, workforce development, and system modernization efforts. States participating in the Rural Health Transformation Program will likely make substantial strategic and financial decisions based upon anticipated funding levels and expected program requirements. Unclear or unstable scoring methodologies may complicate long-term planning and discourage sustained investment in operational improvements that require multi-year implementation horizons. Healthcare systems function most effectively when participating entities possess reasonable certainty regarding program expectations, evaluation standards, and the administrative conditions governing future funding decisions.

CRAE is concerned that undefined or evolving scoring methodologies administered through informal guidance or shifting administrative practices may create significant risk of discretionary drift over time. In large federal programs, agencies may gradually modify operational expectations, evaluative priorities, or scoring interpretations through technical assistance materials, subregulatory guidance, or evolving administrative precedent. Such informal evolution can reduce transparency, weaken predictability, and create uncertainty regarding compliance expectations. Participating states should not be required to infer changing evaluation standards

through informal administrative signals or evolving program management practices that lack clear procedural safeguards or publicly articulated standards.

CMS should therefore provide greater specificity regarding weighting methodologies, benchmark calculations, performance expectations, and the operational criteria that will govern technical scoring determinations. Clearly articulated evaluation standards can improve program transparency while helping participating states better align operational strategies with identifiable program objectives. Greater specificity may also reduce inconsistent interpretations and improve administrative fairness across participating entities. To the extent possible, CMS should identify measurable operational indicators, explain the relative significance of various reporting elements, and clarify how reported information will affect annual funding recalculations and overall program evaluations.

Funding stability is also an important consideration within any long-term healthcare transformation initiative. Rural healthcare systems frequently operate under substantial financial pressures and may face difficulty sustaining long-term operational investments if future funding levels remain uncertain or subject to significant annual volatility. Recalculation systems that produce abrupt or unpredictable funding fluctuations may undermine infrastructure planning, workforce recruitment, technology investment, and broader operational modernization efforts. CMS should therefore seek to structure funding recalculation methodologies in a manner that preserves accountability while avoiding unnecessary instability that could complicate long-term healthcare transformation planning within participating states and rural provider systems.

CRAE further encourages CMS to promote transparency and accountability through regular publication of scoring methodologies, evaluation standards, benchmark criteria, and any material revisions to program assessment frameworks. Publicly available scoring guidance can improve consistency, reduce confusion, and strengthen confidence in the fairness of program administration. Transparency may also help participating states identify operational best practices and improve long-term planning capabilities. Particularly within a program involving substantial federal expenditures and multi-year implementation horizons, clearly accessible evaluation standards are essential to maintaining administrative credibility and ensuring that program participants can reasonably understand how performance determinations are being made.

Finally, CRAE encourages CMS to adopt a transparent, rules-based, and administratively predictable framework governing technical scoring and funding recalculations under the Rural Health Transformation Program. Clear evaluation standards and stable funding methodologies will better support long-term healthcare investment, operational planning, and effective program participation by states and rural healthcare systems. A disciplined and transparent framework will also help reduce uncertainty, minimize discretionary drift, and strengthen confidence in program administration. Ultimately, predictable oversight structures are more likely to support durable healthcare transformation and sustainable operational improvement within rural communities.

V. CMS SHOULD ACCOUNT FOR THE ADMINISTRATIVE CAPACITY CONSTRAINTS OF RURAL STATES AND PROVIDERS

Administrative capacity varies substantially across participating states, rural healthcare systems, and provider organizations. While some large healthcare systems and state agencies may possess extensive compliance infrastructure and specialized administrative personnel, many rural providers and smaller states operate with significantly more limited institutional resources. These disparities can materially affect the ability of participating entities to absorb additional reporting obligations and administrative complexity. CMS should therefore recognize that uniform reporting expectations may produce uneven operational consequences across participants depending upon staffing capacity, technological infrastructure, financial resources, geographic conditions, and existing administrative burdens within individual rural healthcare environments.

Persistent workforce shortages and administrative resource constraints remain significant challenges throughout many rural healthcare systems. Rural hospitals, clinics, and provider networks frequently face difficulty recruiting and retaining not only clinicians, but also financial personnel, information technology staff, compliance specialists, and administrative managers. In many cases, a relatively small number of individuals may already be responsible for overseeing multiple operational, financial, and regulatory functions simultaneously. Additional reporting obligations imposed through the Rural Health Transformation Program may therefore place further strain on already limited institutional capacity and divert scarce personnel resources away from direct operational and patient-care priorities.

Larger healthcare systems and more populous states may also possess structural advantages in managing complex reporting environments due to greater access to compliance infrastructure, legal support, consulting resources, and dedicated data-management personnel. By contrast, smaller rural providers and state agencies may lack comparable administrative support systems or financial flexibility to absorb expanding compliance obligations. As a result, reporting complexity that may appear administratively manageable within larger institutions can impose substantially greater proportional burdens on smaller entities. CMS should remain attentive to these asymmetrical effects when designing reporting expectations and evaluating administrative feasibility across participating states and healthcare systems.

Excessively complex reporting frameworks may also discourage participation or unintentionally disadvantage smaller states and rural healthcare systems that face more limited administrative capacity. If participation in the Rural Health Transformation Program requires development of expansive compliance infrastructure or highly specialized reporting systems, some entities may conclude that administrative costs and operational burdens outweigh potential program benefits. Such outcomes could undermine the broader objective of strengthening rural healthcare access and operational resilience. CMS should therefore ensure that reporting expectations remain proportionate and practically manageable in order to support broad participation and equitable access to program opportunities across differing healthcare environments.

CRAE encourages CMS to preserve reasonable flexibility in reporting implementation, operational design, and performance evaluation in recognition of the diverse conditions facing participating states and rural healthcare systems. Flexible reporting structures can allow states to tailor operational strategies to local healthcare needs, workforce conditions, geographic realities, and institutional capabilities while still maintaining meaningful accountability and oversight. Rigid procedural requirements that inadequately account for operational variation may unintentionally penalize innovative or locally adapted approaches to healthcare improvement.

CMS should therefore emphasize functional outcomes and operational effectiveness rather than imposing unnecessarily prescriptive administrative processes.

CRAE also supports phased implementation mechanisms and robust technical assistance during the early years of program administration. Participating states and rural healthcare systems may require time to develop sustainable reporting infrastructure, integrate technological systems, establish internal procedures, and train personnel responsible for compliance and data management functions. Gradual implementation timelines may help reduce operational disruption while improving long-term reporting quality and administrative consistency. CMS should also consider providing technical guidance, standardized reporting resources, and interoperability support designed to assist participating entities in developing efficient and sustainable compliance systems throughout program implementation.

In sum, CRAE encourages CMS to align reporting expectations with the real-world administrative capacity constraints facing participating states and rural healthcare providers. Effective oversight systems should remain sufficiently disciplined and flexible to accommodate differing institutional conditions while avoiding unnecessary procedural complexity that may disproportionately burden smaller entities. A reporting framework grounded in operational realism and administrative proportionality will better support broad participation, sustainable compliance, and long-term healthcare improvement within rural communities. Ultimately, healthcare transformation efforts are more likely to succeed when administrative obligations remain compatible with the practical operational realities of rural healthcare delivery systems.

VI. CMS SHOULD CONTINUE REFINING THE REPORTING FRAMEWORK TO IMPROVE DURABILITY, EFFICIENCY, AND LONG-TERM ADMINISTRABILITY

Targeted refinements to the Rural Health Transformation Program reporting framework can improve long-term program durability while reducing unnecessary compliance burdens on participating states and rural healthcare systems. Large-scale healthcare transformation initiatives function most effectively when administrative structures remain stable, operationally manageable, and adaptable to evolving healthcare conditions over time. By refining reporting systems at the outset of implementation, CMS can reduce the likelihood of future administrative fragmentation, duplicative compliance obligations, and operational inefficiencies. A carefully calibrated reporting framework will better support both responsible program oversight and the long-term sustainability of rural healthcare transformation efforts.

CRAE encourages CMS to adopt standardized reporting templates, uniform reporting definitions, and clearly structured submission formats across participating states and healthcare entities. Standardization can reduce confusion regarding reporting expectations while improving consistency, comparability, and administrative efficiency throughout the program. Uniform reporting structures may also help reduce time devoted to formatting, interpretation, reconciliation, and procedural coordination. Particularly within complex multi-state initiatives, clearly defined reporting categories and standardized terminology can improve communication between participating entities and federal administrators while reducing unnecessary administrative variability and compliance uncertainty over the course of implementation.

CMS should also prioritize expanded automation, interoperable reporting systems, and integration with existing federal healthcare data infrastructure wherever feasible. Automated submission systems and interoperable platforms may significantly reduce manual reporting

burdens, improve reporting accuracy, and simplify long-term program administration for both CMS and participating entities. To the extent that relevant information is already available through existing Medicare, Medicaid, grant-management, or healthcare quality systems, CMS should seek to leverage those data streams rather than requiring duplicative manual submissions. Technological modernization can help improve administrative efficiency while allowing participating entities to devote greater institutional resources toward healthcare delivery priorities.

CRAE further recommends that CMS periodically reassess whether specific reporting elements continue to provide meaningful operational, evaluative, or administrative value over the life of the program. Reporting systems often expand incrementally over time as new informational requests are layered onto existing frameworks without corresponding review of continuing utility. Periodic reassessment mechanisms can help ensure that reporting obligations remain proportional, relevant, and appropriately connected to identifiable program objectives. CMS should therefore establish procedures for evaluating whether particular reporting requirements continue to justify the administrative burdens imposed on participating states and rural healthcare providers.

CMS should also consider adopting reasonable safe harbors and implementation flexibility mechanisms for good-faith reporting efforts, particularly during early implementation periods when participating entities may still be developing compliance infrastructure and operational procedures. Large transformation initiatives frequently involve technological adjustments, data-integration challenges, and evolving administrative coordination processes that may create temporary implementation difficulties despite diligent compliance efforts. Reasonable flexibility can support broader participation and encourage cooperative problem-solving while still maintaining accountability and program oversight. A balanced implementation approach may improve long-term reporting quality and operational sustainability across participating healthcare systems.

CRAE additionally cautions against expanding substantive reporting expectations through subregulatory guidance documents, informal directives, technical assistance materials, or evolving administrative interpretations that effectively alter program obligations without formal procedural safeguards. Over time, informal administrative expansion can significantly increase compliance complexity and create uncertainty regarding program expectations. Participating states and healthcare providers should be able to rely on stable, clearly articulated reporting requirements rather than navigating evolving informal expectations that may shift through administrative practice. CMS should therefore maintain clear procedural discipline regarding any future modifications to reporting obligations or evaluation standards.

Long-term sustainability should remain a central consideration throughout implementation of the Rural Health Transformation Program reporting framework. Healthcare transformation initiatives often operate over multi-year periods requiring stable operational planning, workforce investment, technological modernization, and institutional coordination. Reporting systems that become excessively complex, unstable, or administratively burdensome may undermine long-term participation and reduce operational effectiveness over time. CMS should therefore prioritize administrable reporting obligations that participating entities can realistically sustain across changing operational, financial, and healthcare conditions while continuing to support meaningful accountability and program evaluation.

For these reasons, CRAE encourages CMS to finalize a reporting framework that remains disciplined, proportionate, technologically modernized, and operationally sustainable throughout the life of the Rural Health Transformation Program. Careful refinement of reporting systems can strengthen program accountability while reducing unnecessary administrative burdens and preserving institutional flexibility for participating states and rural healthcare providers. A durable and administratively manageable framework will better position participating entities to focus resources on improving healthcare access, strengthening operational resilience, and addressing long-term healthcare challenges facing rural communities. Ultimately, sustainable healthcare transformation depends upon oversight systems that remain practical, transparent, and operationally realistic over time.

CONCLUSION

CRAE appreciates the opportunity to submit comments regarding the proposed information collection associated with implementation of the Rural Health Transformation Program. CMS's effort to improve healthcare access, operational coordination, and long-term system sustainability within rural communities addresses issues of substantial national importance. Rural healthcare systems continue to face significant demographic, financial, workforce, and infrastructure pressures that require thoughtful and administratively realistic policy responses. As CMS moves forward with implementation of this major initiative, careful attention to reporting design and administrative structure will play an important role in determining long-term program effectiveness and operational sustainability.

CRAE supports responsible efforts to modernize rural healthcare systems, strengthen healthcare access, and improve long-term operational resilience within underserved communities. Investments that support provider stability, workforce development, infrastructure modernization, emergency care access, and healthcare coordination may provide meaningful benefits for patients and local economies alike. Effective transformation initiatives can help improve service availability and healthcare outcomes while strengthening the long-term viability of rural communities facing persistent economic and demographic challenges. However, the success of such initiatives depends heavily on whether implementation frameworks remain operationally manageable and sufficiently adaptable to real-world healthcare conditions.

At a practical level, reporting systems materially shape how large transformation initiatives function over time. Reporting frameworks influence administrative priorities, resource allocation decisions, institutional incentives, operational flexibility, and long-term participation dynamics among states and healthcare providers. Well-designed reporting systems can support accountability, transparency, and informed program evaluation while minimizing unnecessary administrative burdens. Poorly calibrated systems, by contrast, may gradually shift institutional attention toward procedural compliance activity rather than substantive healthcare improvement. CMS should therefore recognize that reporting architecture is not merely administrative, but a central operational component of the program itself.

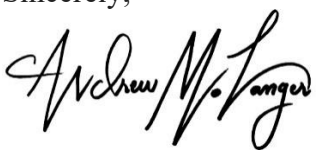
CRAE remains concerned that excessive administrative layering, duplicative reporting structures, and ambiguous evaluative expectations may unintentionally undermine the very healthcare objectives the program seeks to advance. Rural healthcare systems frequently operate under substantial staffing shortages, financial pressures, technological limitations, and constrained administrative capacity. Expansive or evolving reporting obligations may divert scarce managerial and operational resources away from healthcare delivery priorities,

infrastructure investment, workforce retention, and service availability. Over time, excessive procedural complexity may also discourage participation, reduce operational flexibility, and create barriers to sustainable long-term healthcare transformation within rural communities.

Accordingly, CRAE encourages CMS to prioritize transparency, proportionality, interoperability, predictability, and administrative discipline as it finalizes the reporting framework for the Rural Health Transformation Program. Reporting obligations should remain clearly defined, technologically streamlined, outcome-oriented, and closely tied to identifiable operational and evaluative objectives. CMS should also seek to minimize duplication, preserve state flexibility, and avoid unnecessary expansion of administrative obligations through informal guidance or evolving subregulatory expectations. A disciplined and administratively manageable framework will better support both effective program oversight and sustainable healthcare improvement within participating rural healthcare systems.

Ultimately, durable rural-health transformation depends not merely on the scale of federal funding or the volume of collected information, but on whether the underlying administrative framework remains practical, operationally realistic, and capable of supporting long-term healthcare delivery improvement. Effective oversight systems should promote accountability and informed evaluation without imposing unnecessary burdens that weaken institutional capacity or reduce operational flexibility. CRAE therefore encourages CMS to finalize a framework that remains outcome-oriented, economically realistic, technologically modernized, and adaptable to the diverse operational realities facing rural healthcare systems. Such an approach is more likely to support lasting healthcare access, system resilience, and community stability across rural America.

Sincerely,



Andrew M. Langer
President
Main Street Foundation

NEBRASKA
Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

Public Comment on Proposed Information Collection

Rural Health Transformation Program Reporting (Form Number: CMS-10949)

The Nebraska Department of Health and Human Services (Nebraska DHHS) submits the following comment on the proposed collection of information for Rural Health Transformation Program Reporting (Form Number: CMS-10949). Nebraska DHHS appreciates the Centers for Medicare & Medicaid Services' efforts to support program accountability, evaluate state progress, and ensure that Rural Health Transformation Program (RHTP) funds are used responsibly.

At the same time, RHTP is not a routine grant program. It offers a once-in-a-generation opportunity to transform rural health by strengthening access to care, stabilizing essential providers, modernizing technology and data infrastructure, improving workforce capacity, and supporting durable models of care for rural and frontier communities. The reporting framework should reinforce that transformation by giving CMS and the public meaningful insight into progress and stewardship. It should not redirect scarce state, provider, and community capacity into unnecessary bureaucracy that is duplicative, difficult to reconcile, and only marginally useful for understanding outcomes.

Nebraska is fully committed to transparent reporting, fiscal accountability, and responsible implementation of RHTP. Nebraska does not oppose reporting. Rather, Nebraska urges CMS to use a reporting approach that is proportionate to the program's purpose and consistent with established federal grants management tools. CMS can obtain the information needed for oversight through standardized federal reporting, including the SF-424/SF-424A budget framework and the SF-425 Federal Financial Report where applicable or required, paired with clear narrative-based performance reporting. That approach would provide transparency while avoiding the burdens created by the draft template CMS has issued.

I. Duplication of Effort and Unnecessary Bureaucracy

Nebraska DHHS urges CMS to reconsider any conclusion that the proposed collection does not duplicate other reporting efforts. RHTP states already operate within a federal reporting structure that includes approved application and budget materials, budget revisions, financial reporting, grant terms and conditions, audit requirements, and federal monitoring. The proposed template would require states to translate much of the same fiscal information into a separate, program-specific format that may not align

cleanly with accounting systems, subaward documentation, the SF-424/SF-424A budget structure, or the SF-425/FFR.

This is not simply a matter of entering information into another worksheet. Different terminology, coding structures, definitions, and levels of detail create a practical risk that states will be required to report the same activity from multiple perspectives. That can generate apparent discrepancies even when the underlying expenditures are accurate and allowable. In turn, states must spend additional time reconciling, explaining, and validating data solely because the reporting structures do not match.

The result is unnecessary bureaucracy. It does not necessarily strengthen accountability and may instead create a parallel reporting system that draws attention away from the actual questions CMS should be asking: whether funds are being used for approved purposes, whether implementation is proceeding on schedule, whether rural communities are seeing measurable progress, and whether the state is managing risks appropriately. These questions can be answered more directly through existing federal forms, aggregated financial reporting, and narrative explanations tied to milestones, outcomes, barriers, and corrective actions.

II. Annual and Quarterly Reporting Template

Nebraska DHHS also requests that CMS reconsider the level of disaggregation required by the draft annual and quarterly reporting template. The template appears to require states to divide payments when an expenditure relates to more than one initiative, recipient, or use-of-funds category. In a program of this scale, that approach will not always reflect the way rural health transformation is designed, budgeted, contracted, invoiced, or accounted for.

Many RHTP investments will be intentionally cross-cutting. A single initiative or subrecipient award may include workforce development, care coordination, data infrastructure, equipment, provider supports, technical assistance, and other allowable activities. Forcing states to split these activities into numerous line items may obscure rather than clarify what the investment is intended to accomplish. It can also break the connection between the reporting template and the documents that provide the actual audit trail, including subawards, invoices, accounting records, approved budgets, and supporting documentation.

Nebraska is particularly concerned that the draft template would require substantial manual work by program staff, fiscal staff, and subrecipients during the same period in which states are building implementation infrastructure, issuing funding opportunities, executing subawards, and standing up data collection systems. During the early years of RHTP, excessive reporting detail can slow implementation and divert effort from the rural health transformation the President, Congress, and CMS intended to advance.

Nebraska recommends that CMS use a more aggregated, rolled-up reporting structure. States should report planned uses of funds through the approved SF-424/SF-424A budget materials and budget revisions, report expenditures through the SF-425/FFR where applicable or required, and provide narrative reports that explain implementation progress. Narrative reporting can provide information that a line-item template cannot, including the rationale for investments, major milestones, populations and communities served, implementation barriers, lessons learned, changes in strategy, sustainability considerations, and early evidence of impact.

III. Burden Estimates

Nebraska DHHS does not believe the draft burden estimates reflect the actual effort required to collect, collate, validate, reconcile, and report the information requested in the proposed template. The burden is not limited to completing a form. It includes developing guidance for subrecipients, updating invoice and reporting tools, mapping transactions to program-specific categories, reconciling those categories to state accounting data and federal financial reports, resolving inconsistencies, obtaining program and fiscal review, and preparing management-level validation before submission.

The proposed burden estimates also appear to understate the number of staff involved. Accurate RHTP reporting will require coordination among program leads, grants management staff, budget and accounting staff, analysts, legal or procurement staff in some cases, and subrecipients or contractors. The first year of a new program is especially burdensome because states must establish definitions, workflows, quality assurance processes, and reporting expectations while implementation is already underway.

A more realistic estimate for an annual report using the draft template is at least 400 to 520 hours per state, and potentially more depending on the number of initiatives, subrecipients, and cross-cutting awards. This time estimate only accounts for burden at the state level and does not include the mirroring of required reporting at the subrecipient level. Nebraska is on track to engage with state partners across hundreds of subaward and contractual agreements in Budget Period 1 alone. These hours represent time that would otherwise be available for implementation support, technical assistance, monitoring, and direct problem solving with rural partners.

IV. Recommended Alternative

Nebraska DHHS recommends that CMS revise the proposed collection and replace the draft line-item template with a streamlined reporting framework that includes the following elements:

- Use the SF-424/SF-424A budget framework and approved budget revisions as the primary source for planned uses of funds.

- Use the SF-425/FFR, where applicable or required, as the primary standardized source for federal financial reporting and expenditure reconciliation.
- Require narrative-based annual and quarterly reporting using standardized prompts focused on progress, milestones, outcomes, barriers, implementation risks, corrective actions, geographic reach, and sustainability.
- Allow states to provide aggregated use-of-funds and cap-related summaries rather than requiring universal line-level disaggregation of payments across multiple categories.
- Reserve detailed follow-up requests, transaction-level review, or additional documentation for targeted monitoring, material variances, or specific areas of concern.

This alternative would give CMS a clear and auditable view of RHTP implementation while allowing states to report in a manner that aligns with their accounting systems, subaward structures, and program management practices. It would also better support program evaluation by focusing attention on outcomes, implementation progress, and the practical challenges of transforming rural health systems.

Conclusion

Nebraska DHHS appreciates the opportunity to comment on the proposed information collection and values continued partnership with CMS. Nebraska is committed to delivering transparent reporting and demonstrating responsible stewardship of RHTP funds. However, the proposed draft template would impose unnecessary bureaucracy and create significant administrative burden without a commensurate gain in accountability or public understanding.

RHTP is a once-in-a-generation opportunity to improve the future of rural health. CMS should ensure that reporting requirements help states show progress, manage risk, and share meaningful results, rather than requiring duplicative and highly disaggregated templates that pull attention away from implementation. Nebraska respectfully recommends that CMS replace the draft template with a streamlined approach based on standardized federal financial reporting and narrative-based performance reporting. We would additionally like to extend an offer to CMS to walk through the implications of the current financial reporting framework with real-world examples to illustrate the points raised in this public comment.

Sincerely,

Ryan Daly, Deputy Director of Finance and Operations/RHTP Finance Officer

CC: Sara Morgan, Deputy Director of Health Promotion and Prevention/RHTP Director

May 11, 2026
Administrator Mehmet Oz, MD
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: RHT Program Reporting PRA Package (CMS-10949)

On behalf of our respective Rural Health Transformation Program (RHT Program) state programs and/or agencies, we respectfully provide the following comment on the proposed collection of information for the RHT Program Reporting (Form Number: CMS-10949).

We remain committed to working with CMS to ensure the RHT Program achieves its objectives and that State progress is accurately reflected in annual scoring and allocation decisions. We appreciate CMS' efforts to design reporting instruments that adhere to federal mandates and support program evaluation. At the same time, we strongly encourage CMS to consider the proposed reporting framework in the context of a complex, rapidly developing program and to reduce reporting burdens where possible without compromising essential information. Our comment is organized into three sections: I. Duplication of Efforts; II. Annual Reporting Template; and III. Burden Estimates.

I. Duplication of Efforts:

We urge CMS to reconsider its assessment that this information collection does not duplicate any other reporting effort. The Notice of Award requires States to submit the annual Expenditure Federal Financial Report (SF-425/FFR) in addition to quarterly and annual RHT reports. The "Use of Funds" section of the proposed reporting template overlaps with information already captured in the FFR.

While we understand and support CMS' commitment to fiscal accountability and financial management, differences in terminology, categorization, and data definitions are unavoidable because the FFR is a standardized federal form and the RHT template is program-specific. Consequently, States may be required to provide the same fiscal information from two different perspectives, generating unnecessary confusion and administrative burden.

II. Annual Reporting Template:

We request modifications on the Use of Funds reporting approach and the expected level of detail. Given the scale, volume, and highly individualized initiative designs within the

RHT program, some states may obligate funds to more than 150 subrecipients. The RHT Program Annual Reporting Template instructs "if the State determines that a given payment ought to be assigned to more than one initiative, was divided among multiple recipients, and/or applies to multiple use of funds categories, the State should divide the total into multiple lines with an appropriate funding amount assigned to each." This level of disaggregation creates a reporting structure in which approved line-item budgets do not align 1:1 among subrecipients with the Use of Funds category and will generate significant administrative workload. For instance, a single subrecipient that engages in a project involving contractors, provider payments, infrastructure costs, and other Use of Funds categories could generate several separate line entries with multiple use of funds categories.

We encourage CMS to consider a more aggregated ("rolled-up") approach that reduces burden while still capturing necessary information, removing the Use of Funds reporting requirement or offering opportunities to report use of funds by the initiative instead of by the sub-recipient.

III. Burden Estimates:

We do not agree that the burden estimates in Supporting Statement A, Section 12, reflect the actual effort required to collect, collate, validate, and report the information requested in the proposed annual reporting tabs. CMS estimates 12 hours for the annual report and 9 hours for the quarterly report per State, which significantly underestimates the range of staff required (e.g., analysts, budget specialists, program experts) and the extensive coordination needed with subrecipients. Additionally, time is needed to ensure clear guidance is provided to subrecipients, especially within this first year of the RHT Program.

A more realistic – though still modest – estimate is approximately 120 hours (for example, 4 staff contributing 30 hours each) per state to complete the annual reporting requirements.

We appreciate the opportunity to comment on this proposed information collection for the RHT Program and look forward to continued partnership with CMS.

Respectfully,

State of California
Department of Health Care Access and Information

State of Connecticut
Department of Social Services

State of Minnesota
Minnesota Department of Health

State of Oregon
Oregon Health Authority

Commonwealth of Pennsylvania
Department of Human Services

State of Tennessee
Department of Health

Monday May 11, 2026

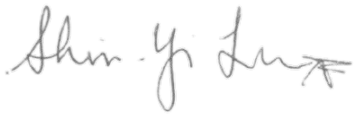
Centers for Medicare and Medicaid Services
Division of Regulations Development
7500 Security Boulevard
Baltimore, MD 21244

Attention: Public Comment for *Rural Health Transformation Program Reporting*
Document Identifier: CMS-10949
OMB Control Number: 0938-TBD
Publication date: 3/11/26
Comments close date: 5/11/26

I am writing on behalf of the team implementing the Rural Health Transformation funding for the State of New Jersey to provide our team's feedback on CMS-10949, the proposed *RHT Program Annual Reporting Template* that would be used to report on a Budget Period's activities every August. Our administrative team includes staff representing our State Medicaid Agency (located within NJ's Department of Human Services) and staff from our State Office of Rural Health (located with NJ's Department of Health).

We raise the following 9 comments for consideration by CMS' Office of Rural Health Transformation. If helpful, we would be happy to follow up on any of our concerns and recommendations upon request. You can contact the NJ Rural Health Transformation administrative team at mahs.njrht@dhs.nj.gov .

We thank you for your consideration,



Shin-Yi Lin, Ph.D.
Deputy Director of Policy and NJ RHT AOR

#	Feature	NJ RHT's Concern	NJ RHT's Recommendation
1	Burden estimated for completion	NJ anticipates substantial staff effort to complete the CMS-10949 template. It is hard to accurately estimate because we need additional guidance from CMS on the intent of some of the fields included in CMS-10949 (see other concerns below), but we currently estimate above 150 staff hours to collect, consolidate, validate, and submit the required data elements.	NJ requests that CMS adopt more realistic estimates for the staff burden associated with completion of the CMS-10949 template. We encourage CMS to consider our state and other states' feedback for non-critical areas to simplify or streamline this reporting template, particularly for Budget Period 1. CMS could make certain fields that are less critical for Budget Period 1 rescoring optional for the 8/30/26 submission. This would give States and CMS a chance to better assess staff burden accurately for key fields, and prioritize operationalization of collection and scoring of the most critical fields for this first round of rescoring in 2026.
2	Proposed submission deadline	We are concerned about the feasibility of states meeting the August 30th deadline for Annual Reporting submission—given that this deadline is on the same date as the annual deadline for the submission of the BP2 Non-competing Continuation (NCC) Application. This August deadline is not explicitly mentioned in the Federal Register material, but this deadline has been shared with RHT staff in all states and is in our Notice of Award.	NJ strongly recommends that CMS adopt staggered deadlines for Annual Reporting and NCC Application submissions. If deadlines cannot be altered in time for the 2026 submissions, we recommend that CMS adopt staggered deadlines for subsequent Budget Periods.
3	Fair scoring using the Checkpoint Model: Comparison to State's own Implementation Plan	NJ seeks a better understanding of how the Checkpoint Model takes into consideration the Implementation Plan in State's approved application.	NJ requests that CMS considers the state-specific context of a State's Implementation Plan in their Annual Report. We recommend that the template focus on scoring State's progress on milestones in relation to what the State proposed for the year being reported on. There should be a reduced

#	Feature	NJ RHT's Concern	NJ RHT's Recommendation
		To illustrate this point, two initiatives: • *State A's Initiative 1 was projected to be at Stage 1 by the end of Budget Period 1 and meets that Stage by end of July.* • *State B's Initiative 2 was projected to be at Stage 0 by the end of Budget Period 1 and meets that Stage by end of July.* We would anticipate that State A would get a better score using the Checkpoint Model of scoring. But, in our estimation, both States have met their proposed Staging by the end of the Budget Period. In that case, we would argue that the two States should receive the same score for Initiatives 1 and 2, all things being equal.	emphasis on early achievement of milestones proposed for completion in subsequent years, for reasons related to the concerns described below around unintended negative consequences.
4	Fair scoring using the Checkpoint Model: Initiatives with different maturity levels	NJ seeks a better understanding of how the Checkpoint Model will be used for scoring and funding allocation as it will be difficult to judge initiatives fairly across states, if the maturity of initiatives differ. To illustrate this point, two states: • *State A: RHT plan includes initiatives that are expansions of prior activities.* • *State B: RHT plan includes initiatives that are novel approaches that require more development before implementation.*	NJ requests that CMS consider that RHT does not inadvertently disincentivize activities that require a longer period of Stage 0-2 investment, as long as that development period is aligned with the innovative nature or complexity of a proposed, novel initiative.

#	Feature	NJ RHT's Concern	NJ RHT's Recommendation
		We would anticipate that State A would get an early advantage in the Checkpoint Model of scoring. A potential unintended consequence is that this could encourage States to focus on lower-lift, lower-impact versions of their proposed activities to maintain their award. We believe that RHT should also support State B's approach, especially if those initiatives have the potential to yield more sustainable, innovative, and impactful outcomes. We anticipate that ambitious activities, ones that could lead to real transformation of how rural health care is delivered, often require more upfront development—and this should not be unduly disincentivized.	
5	Fair scoring using the Checkpoint Model: Initiatives with different funding amounts	NJ seeks a better understanding of how the Checkpoint Model will be used for scoring and funding allocation when the specific funding amounts of initiatives differ. To illustrate this point, two initiatives: • *Initiative A is being funded at $1M and has progressed to Stage 2 by the end of Budget Period 1.* • *Initiative B is being funded at $10M and has progressed to Stage 1 by the end of Budget Period 1.* We would anticipate that Initiative A would get a better score using the Checkpoint Model of scoring.	NJ requests that CMS considers whether additional scoring fields to assess the relative funding amounts of initiatives should be considered to ensure right-sized scoring.

#	Feature	NJ RHT's Concern	NJ RHT's Recommendation
		But for the State, it makes more sense to prioritize efforts on Initiative B getting to Stage 2 than on Initiative A getting to Stage 3, given that Initiative B is funded at ten-times of Initiative A.	
6	The number of *Initiative 1* worksheets per State	NJ RHT is organized using five "umbrella" initiatives that include multiple sub-activities. Is reporting expected to be completed at the "umbrella" initiative level, or the sub-activities level? Either approach introduces concerns. • Option 1: Submit with 5 *Initiative* worksheets at the broadest "initiative" level. Concern: A single worksheet per "umbrella" would be inadequate in accurately communicating the status of the full range of sub-activities. Delay in a single sub-activity (even one that is funded at a small percentage of the overall initiative) would have an outsized negative impact on a State's scoring. • Option 2: Submit with an *Initiative* worksheet for each sub-activity. Concern: Some umbrella initiatives have dozens of sub-activities including multiple sub-awardees for each sub-activity. Submission of several dozens of *Initiative* worksheets would not lead to clarity and comparability in a State's RHT activities.	We recommend that CMS' final guidance gives clear guidance on the unit of "initiative" the State should be reporting on so that States can be judged fairly relative to other States – even if our program-wide approaches differ. We also request confirmation as to whether CMS intends to only use the Checkpoint Model (and *Initiative 1* worksheets) to score States to determine funding allocation.

#	Feature	NJ RHT's Concern	NJ RHT's Recommendation
7	Collection of "Number of People Served" and "Metrics" in *Initiative 1* worksheet per State	NJ agrees that quantitative metrics are important for monitoring. We share these considerations of instances when positive growth in those metrics may not be observed. For example: • A State pursues applying an evidence-based intervention to a rural county, but over time, that RHT activity turns out not to have a noticeable impact because we learn that the intervention is not well designed for rural communities. This "negative result", and the learnings associated with it, are valuable to improve future efforts and we do not want to disincentivize reporting of activities that end up yielding little or no impact. • A State pursues a professional development intervention that focuses on hospital response to low-incidence, high-acuity emergency trauma events. The intervention could be successful in terms of building professional capacity to respond appropriately, but will not necessarily lead to an increase in rural patients served because these high-acuity trauma events could be exceptionally rare.	CMS has presented to States that these numbers will not be used for State scoring to determine funding allocation. NJ agrees with this approach. If CMS decides for later Budget Periods to use these performance metrics to score States to determine funding allocation, we recommend their use in limited cases given our concerns. We would also recommend that States are judged by relative (not absolute) increase in numbers of rural residents served—with a definition of rural population aligned with the State's approved application.
8	*Use of Funds* worksheet	NJ is unclear about the definitions of the column fields. In some cases, the fields do not map to existing fields for tracking and monitoring requested by CMS. In other cases, the fields will not cleanly map in real-world funding situations. Specific examples include:	CMS has presented to States that the *Use of Funds* worksheet will not be used for State scoring to determine funding allocation. NJ agrees with this approach.

#	Feature	NJ RHT's Concern	NJ RHT's Recommendation
		• "ID" – Unclear what it is intended to uniquely identify • "Spent funds" – How does this relate to other existing fields for tracking and monitoring like "obligated funds" and "expended funds"? • "Recipient category" – Unclear what the universe of available categories are • "Use of Funds" – How are States to make a single assignment if activities have multiple fund uses (for example, a behavioral health initiative involving innovative tech)	We ask that CMS provide detailed definitions of column fields to ensure that States can consistently fill out worksheet. We ask that CMS redesign collection of any fields that cannot be consistently assigned (i.e. "Use of Funds").
9	Budget Period 1 considerations	A significant portion of NJ's activities in the first quarter of Budget Period 1 include critical administrative elements that set up the capacity for future NJ RHT operations and State oversight, such as: • Hiring of key personnel (such as Project Director) • Governance and stakeholdering strategies The CMS-10949 template does not provide States with any opportunity to report on these important RHT-wide activities that are particularly important for Budget Period 1. The template is only focused on hiring and governance in the more limited, individual initiative level.	We recommend that CMS consider how States can demonstrate progress on RHT-wide implementation.

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CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

Comment On: CMS-2026-0991-0001
CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

Document: CMS-2026-0991-DRAFT-0008
Comment on CMS-2026-0991-0001

Submitter Information

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General Comment

In the Sample Reporting Template (Excel file), we suggest that the Use of Funds column be a SELECT ALL THAT APPLY field rather than a Dropdown (select one) because activities often fall into multiple use categories.

For example, our Diabetes initiative that plans to hand out continuous glucose monitors could fall under "Prevention and Chronic Disease" or "Consumer Tech Solutions".

If the Use of Funds ends up being a single selection dropdown, we request that CMS provides more detailed definitions of what falls into each category so that there is no overlap between them and it is clear how an activity or expense should be catagorized.

Thank you.

Attachments

DRAFT_State_Reporting_Template

PUBLIC SUBMISSION

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CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

Comment On: CMS-2026-0991-0001
CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

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Comment on CMS-2026-0991-0001

Submitter Information

Email: federarealtions@nihb.org
Government Agency Type: Tribal
Government Agency: CMS Tribal Technical Advisory Group

General Comment

See attached file(s)

Attachments

CMS TTAG RHTP Reporting Comments - 5.7.2026

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CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

Document: CMS-2026-0991-DRAFT-0010
Comment on CMS-2026-0991-0001

Submitter Information

Email: glankford@nihb.org
Government Agency Type: Tribal
Government Agency: The Centers for Medicare and Medicaid Services Tribal Technical Advisory Group

General Comment

See attached file(s)

Attachments

CMS TTAG RHTP Reporting Comments - 5.7.2026

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CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

Comment On: CMS-2026-0991-0001
CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

Document: CMS-2026-0991-DRAFT-0013
Comment on CMS-2026-0991-0001

Submitter Information

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Organization: Federation of American Hospitals

General Comment

Please see the attached comments from the Federation of American Hospitals regarding the collection and reporting of Rural Health Transformation Fund data.

Attachments

RHTF_PRA_Comments

PUBLIC SUBMISSION

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CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

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CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

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Comment on CMS-2026-0991-0001

Submitter Information

Email: andrew@cooperativepolicy.org
Organization: Main Street Foundation Center for Regulatory Analysis and Engagement

General Comment

Attached are comments from the Main Street Foundation Center for Regulatory Analysis and Engagement.

Attachments

MSF CRAE HHS CMS Comments Rural Hospitals ICR FINAL 051126

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CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

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Comment on CMS-2026-0991-0001

Submitter Information

Email: ryan.daly@nebraska.gov
Government Agency Type: State
Government Agency: Nebraska Department of Health and Human Services

General Comment

Nebraska DHHS comment is attached.

Attachments

Public Comment NE CMS-10949

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CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

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Comment on CMS-2026-0991-0001

Submitter Information

Email: yudi.liu@oha.oregon.gov
Government Agency Type: State
Government Agency: Multiple

General Comment

See attached file(s)

Attachments

CMS RHTP Proposed Collection Comment_FINAL

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Comment On: CMS-2026-0991-0001
CMS-10949 (Rural Health Transformation (RHT) Program Reporting)

Document: CMS-2026-0991-DRAFT-0017
Comment on CMS-2026-0991-0001

Submitter Information

Email: mahs.njrht@dhs.nj.gov
Government Agency Type: State
Government Agency: NJ RHT team (NJ Dept of Human Services, NJ Dept of Health)

General Comment

NJ's RHT team provides public comment for proposed Rural Health Transformation Program Reporting. We raise the following 9 comments in the attached document for consideration by CMS' Office of Rural Health Transformation. -- Shin-Yi Lin, PhD (NJ DHS, NJ RHT Authorized Organization Representative) submitting on behalf of NJ RHT's implementation team

Attachments

2026-05-11FINAL NJRHT CMS-10949_Public Comment