CMS Response to Public Comments Received for CMS-10949

The Centers for Medicare and Medicaid Services (CMS) received one comment from a Critical Access Hospital (CAH), two comments from rural health membership organizations, three comments from health and hospital associations, and two comments from State health agencies, for a total of 8 unique, in-scope comments. Comments received provided feedback on the estimated burden of the proposed reporting requirements, noting that the financial reporting requirements may place a disproportionate administrative burden on smaller entities and subawardees. Additionally, commenters expressed a desire for the Rural Health Transformation (RHT) Program data to be made publicly available for increased transparency. CMS acknowledges the time and resources needed to fulfill programmatic reporting activities. To ease burden, reporting templates will be tailored to each State and select data will be pre-populated. In response to public comments and additional internal review, CMS will further reduce burden by consolidating downstream entity data collection and only requiring States to submit first-tier subrecipient information as part of the initial Annual report submission. Reporting for downstream entities will begin with the first Quarterly report. Lastly, CMS is committed to sharing summary data publicly in a timely manner. Below is the reconciliation of the comments.

Comment #1: CMS received a comment from a Critical Access Hospital (CAH) submitting feedback regarding the RHT Program reporting burden estimates, the need for automated data extraction tools, the impact of data collection on small businesses, and how the current reporting structure may impact future funding. The commenter indicated that while the States are the primary respondent to CMS for program reporting, they cannot generate the data independently and that the reporting requirements flow directly down to subawardees at the local level. The commenter indicated that the proposed burden is underestimated and that it does not account for smaller providers with limited administrative capacity to track funds and provide extensive documentation to States. They indicated that facilities with limited administrative capacity may struggle with the reporting requirements, which they believe could potentially impact scoring and future funding. The commenter also noted inefficiencies with the manual data entry process and

expressed a concern that transitioning to a web-based tool would not fully address these issues. To address burden concerns, they advocated for a standardized and automated data-extraction tool that can integrate with hospital Electronic Medical Records (EMRs) and financial software. The commenter suggested CMS streamline the reporting requirements, provide automated data extraction tools, and refine the administrative burden estimate to reflect the operational impact on rural subawardees.

CMS Response: CMS thanks the commenter for their recommendations. To help reduce burden, reporting templates will be tailored for each State and some information will be pre-populated in the Annual Report for Budget Period 1 with initiative information, including names, numbers, metrics, and state policy action commitments. For all subsequent reporting periods, the Program will transition to a dedicated web-based reporting tool and data will be pre-populated based on the previous reporting period's submission. States will receive guidance on completing their reporting requirements, along with optional resources that can be leveraged, such as a template for project plans, to clarify requirements and ease the data collection burden on State awardees. CMS will reduce burden by consolidating downstream entity data collection and phasing in required reporting elements. Specifically, States will only be required to submit first-tier subrecipient information as part of the initial Annual Report submission. Reporting for downstream entities will begin with the first Quarterly Report. Information collected through this reporting will support program oversight, monitoring, analysis, applicable rescoring activities, and the identification of future technical assistance needs. However, Obligated and Spent Funds reporting does not impact rescoring decisions. Additionally, States may use RHT Program funds for allowable costs associated with meeting program reporting requirements and may make funding available to subrecipients for allowable reporting-related costs, consistent with applicable program requirements and Federal cost principles.

Comment #2: CMS received a comment from a health and hospital association expressing support for the accountability and evaluation of the RHT Program and conveyed that reporting requirements should balance accountability with the administrative realities faced by rural hospitals and subawardees. The commenter

indicated that reporting should not divert limited resources away from care delivery and recommended that CMS align State and Federal reporting requirements to avoid potential duplication. The commenter recommended CMS ensure that performance-based funding methodologies are fair, transparent, and account for rural realities by emphasizing improvement over time rather than absolute thresholds. The commenter also highlighted the need for flexibility, streamlined reporting, and technical assistance for smaller rural hospitals with limited administrative capacity. Finally, the commenter recommended reducing administrative burden by leveraging existing Federal measures and utilizing a phased implementation to ensure success.

CMS Response: CMS thanks the commenter for their suggestions. As the RHT Program is a cooperative agreement, CMS is committed to supporting an ongoing partnership with States. Data collection via the Annual and Quarterly Reports is essential to the annual reassessment of each State's technical score, which directly determines their performance-based workload funding for subsequent budget periods based on their reported progress over time. Furthermore, RHT Program reporting serves a fundamentally different purpose and is distinct from other Federal reporting requirements. This data collection captures detailed programmatic and financial information, including initiative level obligations, downstream entity tracking, use of funds, checkpoint progress, and performance data. This information also supports program oversight and monitoring, technical assistance, and may be used for programmatic audits and financial management reviews. To ease burden, reporting templates will be tailored for each State and some information will be pre-populated in the Annual Report for Budget Period 1 with initiative information, including names, numbers, metrics, and state policy action commitments. For all subsequent reporting periods, the Program will transition to a dedicated web-based reporting tool and data will be pre-populated based on the previous reporting period’s submission. States will receive guidance on completing their reporting requirements, along with optional resources that can be leveraged, such as a template for project plans, to clarify requirements and ease the data collection burden on subrecipients. Additionally, States may use RHT Program funds for reporting costs and may choose to make those funds available to subawardees.

Comment #3: CMS received a comment from a rural health membership organization expressing support for CMS's efforts to modernize rural health and promote accountability by requesting that data collected under this program be made publicly available to ensure transparency and public oversight. The commenter indicated that while the reporting requirements create a rich dataset, the PRA materials do not specify if CMS intends to publish this data. The commenter noted that public access would allow rural communities to see how funds are being used, encourage cross-State learning, build trust, and enable researchers to evaluate program effectiveness. Citing other publicly available CMS data from Medicare and Medicaid programs, and CMS demonstrations, the commenter requested that CMS commit to an annual public release of RHT Program data, including initiative checkpoint completion, obligated and spent funds, and sustainability planning summaries. Additionally, the commenter encouraged the creation of a public-facing dashboard or downloadable dataset.

CMS Response: CMS thanks the commenter for their feedback. Data collection via the Annual and Quarterly Reports provides visibility into how programmatic funds are spent by States, including allocation by subrecipients, subawardees, and contractors (e.g., State agencies, Tribal entities, etc.), distribution across initiatives, and compliance with program-specific limitations. The information collected supports effective program administration, oversight, and stewardship of Federal funds by enabling CMS to assess implementation progress, identify technical assistance needs, promote accountability, and monitor compliance with statutory and programmatic requirements. While CMS anticipates that it will not make individual State-reported information public, it is committed to making summary data public in a timely manner.

Comment #4: CMS received a comment on behalf of two State health agencies expressing that the proposed reporting requirements place an undue burden on subrecipients and downstream entities. The States expressed concerns related to the level of detail in Use of Funds reporting, unclear definitions pertaining to Downstream Obligations reporting, and low proposed burden estimates. They indicated that the proposed method for reporting Use of Funds is unduly detailed, requiring States to break down funding into numerous line items, creating a

significant administrative workload. They expressed concerns that the proposed reporting structure may not align with the detailed cost breakdown already captured in each subrecipient's budget information form (SF-424A). The commenters recommended a more aggregated reporting approach organized by initiative rather than by individual subrecipients. The commenters also requested a clearer operational definition of "downstream entity". They indicated that the proposed reporting framework would increase the reporting burden by requiring States to track and report on multiple tiers of subrecipients and contractors, which they found inconsistent with other CMS grant and cooperative agreement practices. The commenters noted that the proposed burden estimates are significantly understated and do not accurately reflect the reporting workload. They recommended adjusting the estimate to 320 hours per report per State.

CMS Response: CMS thanks the commenters for their feedback. The RHT Program reporting structure is intentionally designed to support critical program goals. To support the appropriate use of funds and ensure alignment with the authorizing statute and program requirements, the State reporting template captures detailed, program-specific expenditure information. Data collected through Annual and Quarterly reporting serves a fundamentally different purpose and is distinct from other Federal financial reporting requirements. The RHT Program reporting captures detailed programmatic and financial information, including initiative level obligations, downstream entity tracking, use of funds, checkpoint progress, and performance data. This information supports program oversight and monitoring and may also be used for programmatic audits and financial management reviews. CMS will reduce burden by consolidating downstream entity data collection and phasing in reporting requirements. States will only be required to submit first-tier subrecipient information as part of the initial Annual Report submission. Reporting for downstream entities will begin with the first Quarterly Report. Moreover, reporting templates will be tailored for each State, and select information will be pre-populated. For subsequent reports, the Program will transition to a dedicated web-based reporting tool and previously reported data will automatically be carried forward from the previous reporting period, reducing the need for duplicate data entry. To support States in fulfilling their reporting requirements, CMS provides ongoing technical assistance and guidance.

Comment #5: CMS received a comment from a rural health membership organization expressing appreciation for the investment in the RHT Program and suggesting that CMS make State RHT Program reports publicly available in a timely and accessible manner to promote transparency and accountability. The commenter indicated that rural healthcare facilities are a primary point of access to care for rural residents. They noted that public data on funding is a central measure of the Program's success, helping to ensure that RHT Program funds reach the rural communities they are intended to serve. The commenter noted that public access would allow rural stakeholders to see how funds are being used, identify gaps in services, and learn from successful funding strategies to replicate innovative solutions.

CMS Response: CMS thanks the commenter for their input and feedback. While CMS anticipates that it will not make individual State-reported information public, it is committed to making summary data public in a timely manner. RHT Program Annual and Quarterly Reports provide visibility into how programmatic funds are spent by States, including allocation by subrecipients (e.g., State agencies, Tribal entities, etc.), distribution across initiatives, and compliance with program-specific limitations. The information collected supports effective program administration, performance monitoring and oversight, and stewardship of Federal funds by enabling CMS to assess implementation progress, identify technical assistance needs, promote accountability and transparency, and monitor compliance with statutory and programmatic requirements.

Comment #6: CMS received a comment from a hospital association, which recommended that CMS lift the limitations on provider payments and infrastructure and allow for major construction. The commenter also requested that CMS provide States with greater flexibility and reduce administrative burdens. Specifically, the commenter suggested that CMS work with Congress to allow States to revise their initial applications and provide a longer timeline to spend obligated funds, enabling them to refine the scale and scope of their initiatives. The commenter also requested that CMS publicly post detailed, standardized funding information to ensure stakeholders can track whether funds intended for hospitals reach them. Finally, the commenter requested that CMS and States do

not enact undue administrative barriers, such as complex bureaucratic processes or excessive paperwork, that could delay or prevent hospitals from receiving the support they need.

CMS Response: CMS thanks the commenter for their input and recommendations. Information from the data collection supports effective program administration, performance monitoring and oversight, and stewardship of Federal funds. States must use funds for the purposes stated in the Notice of Funding Opportunity (NOFO) and approved by CMS in their initial application. New construction is unallowable, including directing funding toward new builds or supplanting in-process or planned projects. Program-linked renovations are permitted but capped at 20% of the CMS award per budget period. Similarly, provider payments are capped at 15% and cannot duplicate billable services or replace insurance-reimbursable care. To fund direct services, States must justify why they are not already reimbursable, how they fill coverage gaps, or how they transform care delivery. While CMS anticipates that it will not make individual State-reported information public, it is committed to making summary data public in a timely manner. To help reduce administrative burden, reporting templates will be tailored for each State, and some information will be pre-populated in the Annual Report for Budget Period 1 with initiative information, including names, numbers, metrics, and state policy action commitments. For all subsequent reporting periods, the Program will transition to a dedicated web-based reporting tool and data will be pre-populated based on the previous reporting period's submission. Lastly, States may annually adjust their budget or make other administrative changes using the NCC application. All changes must be in scope and aligned with a State's initial approved application, as scoring and funding amounts were determined based on their original submission. For subsequent budget periods, CMS will re-calculate each State's technical score based on reported progress, which will adjust the workload funding amount accordingly. Therefore, any requested changes must be substantiated with performance data and approved by CMS.

Comment #7: CMS received a comment from a hospital association suggesting that the information collection should support meaningful program oversight and accountability while minimizing unnecessary administrative burden and providing

States with clear and consistent expectations. The commenter commended CMS's addition of more detailed subrecipient reporting structure, citing that this will provide visibility into the flow of programmatic funds. The commenter recommended CMS reconsider its decision not to publish the collected data and instead develop a public facing portal. Further recommendations included requiring provider identifiers in reporting, capturing the full funding chain, lifting provider payment caps, and providing States with greater flexibility to modify approved projects and spend obligated funds.

CMS Response: CMS thanks the commenter for their recommendations. The data collection via the Annual and Quarterly Reports provides visibility into how programmatic funds are spent by States, including how funds are allocated to healthcare provider subrecipients (e.g., Critical Access Hospitals, Rural Emergency Hospitals, etc.). States will submit first-tier subrecipient information as part of the initial Annual Report submission. Reporting for downstream entities will begin with the first Quarterly Report. Information from the data collection supports effective program administration, performance monitoring and oversight, and stewardship of Federal funds. While CMS anticipates that it will not make individual State-reported information public, it is committed to making summary data public in a timely manner. States must use funds for the purposes stated in the NOFO and approved by CMS in their initial application. Provider payments are capped at 15% and cannot duplicate billable services or replace insurance-reimbursable care. To fund direct services, States must justify why they are not already reimbursable, how they fill coverage gaps, or how they transform care delivery.

Comment #8: CMS received a comment from a State health agency expressing concerns that the proposed information collection is duplicative, burdensome, and unclear. The commenter indicated that the reporting requirements overlap with the Non-Competing Continuation (NCC) application and other reporting requirements already provided by the CMS Office of Acquisition and Grants Management (OAGM). The commenter also expressed that the process of tracking funds through multiple tiers of subrecipients and contractors would require considerable staff time. The commenter expressed that the reporting forms, instructions, and key terms lack clarity. They are unsure how this data collection

effort will impact the technical scoring that determines future funding for each State. Additionally, the commenter highlighted the challenge of being required to prepare for the first Annual report, due in August 2026, without having access to the final, approved reporting template. Their comment also included a list of questions pertaining to guidance documents, webinar materials, the reporting template, and other PRA package components.

CMS Response: CMS thanks the commenter for their feedback and questions. The RHT Program reporting structure is intentionally designed to support critical program goals, including promoting financial transparency and enabling effective program oversight, without duplicating other Federal reporting requirements. Moreover, CMS will re-calculate each approved State's technical score and corresponding workload funding amount for each subsequent budget period based on the information and data the approved State provides in the required annual reporting each year. To support the appropriate use of funds and ensure alignment with the authorizing statute and program requirements, the State reporting template captures detailed, program-specific expenditure information. Data collection via the Annual and Quarterly Reports provides visibility into how programmatic funds are spent by States, including allocation by subrecipients, subawardees, and contractors (e.g., State agencies, Tribal entities, etc.), distribution across initiatives, and compliance with program-specific limitations. This approach provides CMS with greater visibility into how program funds are allocated and utilized. This information cannot be captured from any other data source. CMS will reduce burden by consolidating downstream entity data collection and phasing in required reporting elements. States will only be required to submit first-tier subrecipient information as part of the initial Annual Report submission. Reporting for downstream entities will begin with the first Quarterly Report. Moreover, reporting templates will be tailored for each State, and select information will be pre-populated. For subsequent reports, previously reported data will automatically be carried forward from the previous reporting period, reducing the need for duplicate data entry. To support States in fulfilling their reporting requirements, CMS provides ongoing technical assistance and guidance.