

June 8, 2026

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

RE: CMS–1849–P; Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2027 Rates; Requirements for Quality Programs; and Other Policy Changes; RIN 0938–AV79

Dear Administrator Oz:

On behalf of the Council of Academic Family Medicine (CAFM), including the Society of Teachers of Family Medicine (STFM), Association of Departments of Family Medicine (ADFM), Association of Family Medicine Residency Directors (AFMRD), and NAPCRG, as well as the American Academy of Family Physicians (AAFP), we write to provide comments on the Fiscal Year (FY) 2027 Medicare Inpatient Prospective Payment System (IPPS) [proposed rule](#).

Geographical Definition Considerations

The current Health Professional Shortage Area (HPSA) methodology, which designates geographic areas, populations, or facilities experiencing shortages of primary, dental, or mental health care providers, creates significant and unintended barriers for rural hospitals seeking to access Medicare Graduate Medical Education (GME) residency slots. Despite serving communities with documented and persistent workforce shortages, geographically rural hospitals are consistently excluded because their HPSA scores fall below required thresholds or because they are not located within a designated HPSA at all.

This structural flaw is compounded by the inherent instability of HPSA designations in rural areas. Smaller population bases mean that modest changes, such as a residency program adding faculty or retaining graduating residents, can trigger sudden HPSA score shifts that disqualify a community from eligibility, even when the underlying shortage remains. Given these considerations, **we strongly urge CMS to update the definition of rurality to align with its own established criteria, specifically non-metropolitan designations, and to guarantee no less than 10% of available slots to rural areas regardless of HPSA score, in keeping with the legislative intent of expanding GME access to underserved communities.**

Proposed Payment Adjustment for Low-Volume Hospitals (§ 412.101); Proposed Changes in the Medicare-Dependent, Small Rural Hospital (MDH) Program (§ 412.108)

Rural hospitals across the U.S. are operating under significant and worsening financial strain, due in large part to structural challenges in how hospital payment and financing systems are designed.ⁱ Over the past decade, more than 100 rural hospitals have closed and dozens more have eliminated inpatient services, leaving millions of patients without access to emergency, inpatient, and other essential hospital care in their communities. At the same time, more than 700 rural hospitals are now at risk of closure due to sustained financial losses, low reserves, and inadequate reimbursement.ⁱⁱ These closures contribute to an increased number of communities with limited or no local access to hospital-based services, requiring patients to travel long distances to obtain essential care. There are also cascading effects on workforce stability, as physicians and other clinicians are more likely to leave communities without a viable health care infrastructure in search of employment.ⁱⁱⁱ Even hospitals that remain open are increasingly forced to scale back services to remain financially viable, further limiting patients' access to care.^{iv} **In this context, payment policies affecting low-volume and Medicare-dependent rural hospitals are critical not only to supporting hospital solvency but also to preserving access to care in rural communities.**

The Medicare Low-Volume Hospital (LVH) payment adjustment plays a critical role in helping geographically isolated hospitals manage the higher costs associated with low patient volume. When first implemented, only five rural hospitals qualified for the adjustment. Today, nearly 500 rural hospitals receive this additional payment, which helps offset fixed operating costs that often exceed revenue. The LVH adjustment remains an essential tool for supporting the financial viability of rural hospitals facing persistent challenges in scale and sustainability.^v

Similarly, the Medicare-Dependent Hospital (MDH) program was designed to support hospitals that serve a high proportion of Medicare patients and are particularly vulnerable to inadequate Medicare payments.^{vi} Unlike other hospitals, MDHs have limited ability to offset shortfalls through private insurance payments. Both programs have been routinely reauthorized by Congress but are currently set to expire on December 31, 2026, absent further legislative action.

Our organizations support efforts to extend critical financial protections for rural hospitals. Without congressional action, the expiration of these programs would place many facilities under significant financial strain, jeopardizing access to care in rural communities. The ongoing uncertainty has already discouraged much-needed investment in primary care infrastructure, workforce, and patient services, which makes it difficult for hospitals to plan confidently for the future. **We stand ready to work with CMS, Congress, and other stakeholders to end this frustrating cycle and instead develop and implement long-term solutions to the financial challenges facing rural hospitals.**



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While we recognize CMS is bound by current law and cannot act preemptively in place of Congress, the agency can take meaningful administrative steps to help mitigate disruptions if there were to be a lapse in authorization. These actions can provide greater predictability for hospitals operating under tight margins and ensure continuity of care during periods of uncertainty.

Prior to December 31, 2026, CAFM and the AAFP recommend CMS:

- Clearly communicate how it will implement program extensions if such extensions are passed after the expiration date;
- Prepare systems to facilitate expedited retroactive payments in the event of a temporary lapse of either/both programs;
- Engage stakeholders early to establish lines of communication, minimize confusion, and mitigate any potential delays in reimbursement; and
- Signal readiness to support impacted hospitals with technical guidance and financial planning resources.

We thank CMS for outlining the financial methodologies for both scenarios—extension or lapse—in the proposed rule, and we urge the agency to proactively plan for both scenarios as outlined above to ensure continuity of care and financial stability for rural physicians serving some of the nation’s most under-resourced communities.

Payment for Indirect and Direct Graduate Medical Education Costs (§§ 412.105 and 413.75 through 413.83)

Proposed Requirements to Prohibit Unlawful Discrimination by Graduate Medical Education Programs

CMS currently defines “approved medical residency programs” as those accredited by recognized national organizations (e.g., ACGME, AOA, CODA, CPME) or those that lead to board certification. These programs are eligible for Medicare funding through Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) payments. The methodology for calculating these payments is based on hospital-specific per-resident amounts (PRAs) and the number of full-time equivalent (FTE) residents, adjusted for Medicare’s share of inpatient days and teaching intensity.

Executive Order 14279 directs federal agencies to investigate and eliminate diversity, equity, and inclusion (DEI)-related standards in medical education accreditation. In order to comply, CMS revised the criteria for medical residency programs to qualify as “approved” residency programs in the CY 2026 OPPS/ASC final rule. The criteria now prohibits accrediting bodies from requiring or encouraging DEI initiatives that may unlawfully discriminate based on race.

The Department proposes extending this policy, which previously only applied to GME accrediting bodies, to individual approved medical residency programs. Under this proposal, residency programs must not discriminate or promote discrimination based on race, color, national origin, sex, age, disability, or religion, including through the use of proxies for these characteristics in employment or resource allocation decisions. The Department states that this requirement is necessary to prevent discriminatory practices at the program level, even where accrediting standards prohibit such conduct. The proposed policy would take effect October 1, 2026.

While we support the Department’s efforts to ensure that GME programs operate in compliance with applicable federal nondiscrimination laws and appreciate the agency’s intent to prevent discriminatory practices at the program level, our organizations encourage CMS to reconsider this proposal. We have long [supported](#) federal, state, and local initiatives that encourage medical students and residents to pursue careers in family medicine, especially in rural and under-resourced communities. We [believe](#) that a family medicine workforce reflective of the American population results in better education outcomes at all levels of training and improves health outcomes for all Americans. Diverse physician teams are better equipped to understand upstream drivers of health and build trust with patients, particularly for vulnerable populations.^{vii}

If finalized, this proposed rule could pose significant challenges for family medicine residency programs, many of which are community-based and rely on Medicare GME funding. Programs may be forced to revise recruitment strategies and curricula to comply with new federal standards, even when such changes conflict with clinical priorities and community needs.

CMS’ proposal to revise the definition of “approved” residency programs has the potential for significant disruption to the family medicine residency pipeline. According to the Primary Care Scorecard, only 24.4% of new physicians entered primary care in 2022, and just 19.8% did so outside of hospital-based settings.^{viii} This marks the lowest rate in a decade, despite growing demand for primary care services. The lack of funding for community-based training programs further compounds this issue, limiting the number of new family physicians entering the workforce. A shrinking primary care workforce has direct public health and financial consequences. In 2022, more than 30% of U.S. adults already lacked a usual source of care – the highest level in a decade.^{ix} This gap is likely to widen if the primary care pipeline continues to shrink, which would be further expedited by this change. As such, we urge the Department not to move forward with this proposal.

Proposed Modifications to the Criteria for New Residency Programs

CAFM and the AAFP appreciate CMS’ thoughtful proposals to refine the criteria for new

residency programs and incorporate targeted exceptions that reflect the operational realities GME programs face. We support the inclusion of these exceptions, as they appropriately recognize the need for flexibility in program development, particularly for residents entering through binding matching processes, those affected by program disruptions, and participants in small or developing programs. These provisions are key to ensuring that residency programs can recruit and train physicians effectively without jeopardizing program eligibility under rigid thresholds. We encourage CMS to monitor the implementation of these exceptions to identify any unintended impacts, particularly on rural and community-based programs that often rely on flexible recruitment pathways and may be disproportionately impacted by overly restrictive requirements.

e(2) Proposed Removal of Restrictions on Experienced Faculty and Staff

The Department proposes to remove existing restrictions that consider the prior experience of faculty and program leadership when determining whether a residency program qualifies as “new” for Medicare GME purposes. Under this approach, the presence of experienced faculty, including program directors and teaching staff who have previously participated in training programs in the same specialty, would no longer adversely affect a program’s eligibility for new program designation. The Department indicates that this change is intended to reduce ambiguity and align Medicare policy with accreditation expectations, which often require experienced leadership for program development. This modification is also intended to facilitate the establishment of new residency programs by allowing institutions to leverage existing clinical and educational expertise without jeopardizing eligibility for GME funding.

Our organizations strongly support the Department’s proposal to remove restrictions on experienced faculty and staff when determining whether a residency program qualifies as “new” for Medicare GME purposes. Allowing programs to leverage experienced faculty and program leadership is essential to ensuring high-quality training environments and aligns with longstanding AAFP policy supporting [robust preceptorship and mentorship opportunities](#) across the medical education continuum. Experienced physicians play a critical role in training future family physicians, particularly in community-based settings where continuity, supervision, and hands-on learning are foundational to effective education. This policy change will help reduce unnecessary regulatory barriers that may discourage the development of new residency programs, thereby supporting broader efforts to expand training capacity and enable medical students to pursue family medicine careers. By facilitating the responsible use of experienced faculty, the Department’s proposal advances both educational quality and workforce development goals that are critical to strengthening the primary care pipeline.

e(4) Proposed Exceptions for Certain Categories of Residents

The Department proposes to establish targeted exceptions to the requirement that at least 90% of residents in a new program must not have prior training in the same specialty, in order to preserve flexibility in common training pathways. The proposal would create a limited exception

to the counting rules for residents admitted through the National Resident Matching Program (the Match) or other binding third-party matching programs, recognizing that institutions have limited discretion over the mix of matched candidates. Additional exceptions would apply to categories such as displaced residents and participants in smaller or developing programs, where strict application of the threshold could impede program viability.

We support the Department’s proposed exceptions to the resident counting requirements, including the limited exception for residents admitted through the Match and other binding matching pathways. We agree with CMS that institutions have limited discretion over these outcomes and should not be penalized for participating in standardized processes. We particularly support the inclusion of exceptions for displaced residents and those in smaller or developing programs, as these flexibilities are critical to ensuring that new and community-based residency programs can grow and remain stable. By preserving program eligibility in these circumstances, the proposal will help reduce unnecessary barriers to establishing new training opportunities and support the expansion of the family medicine workforce.

e(5) Proposed Exception for Small Programs

The Department proposes to establish an exception to the 90% “new resident” requirement for small residency programs, recognizing the unique constraints these programs face in recruitment and staffing. Specifically, CMS proposes to define a “small” program as one accredited for 16 or fewer resident or fellow positions, regardless of geographic location. This proposal is intended to support the development and sustainability of small programs by reducing barriers to qualifying as a new residency program while maintaining program integrity.

Our organizations strongly support the Department’s proposal to establish an exception to the 90% “new resident” requirement for small residency programs. This flexibility is essential to advancing policies that expand and sustain the family physician workforce, particularly as small and community-based programs play a critical role in training physicians who practice in rural and underserved areas. As reflected in [AAFP policy](#), strengthening the primary care workforce requires removing barriers to the development of new training programs and supporting diverse pathways for physician entry into family medicine, especially in areas with the greatest need. By reducing administrative and structural constraints on small programs, this proposal will promote workforce growth, enhance [training capacity in rural](#) and community settings, and support a more equitable distribution of the physician workforce.

Modification of New Program Cap-Setting Window

We support Congress' work in the Consolidated Appropriations Act of 2021, Section 131, allowing certain hospitals to reset their low PRAs and GME caps. However, the timeline established under that provision did not allow sufficient time for rural and underserved hospitals to fully take advantage of the opportunity. Hospitals in these communities, often operating with fewer resources and less administrative infrastructure, faced unique and significant barriers to

recruitment, program development, and the structural groundwork required to successfully reset their caps within that window.

The unfortunate result was that the hospitals with greatest need were less equipped to act in time. **We urge CMS to revisit this issue and extend the cap-building period going forward. Specifically, we recommend a 10-year cap-building period to give rural and underserved hospitals a meaningful and realistic opportunity to develop sustainable residency programs.** We further urge CMS to consider removing GME caps entirely for small rural hospitals, recognizing that these caps serve as a structural barrier to workforce development in the communities that need physicians most. Expanding this timeframe would improve the quality and long-term sustainability of new and growing residency programs, ultimately benefiting both medical education and patient care.

Proposed Changes to the Medicare Promoting Interoperability Program

2(b) Proposed Updates to the Definition of Certified Electronic Health Record Technology in the Medicare Promoting Interoperability Program

The Department proposes to update the definition of Certified Electronic Health Record Technology (CEHRT) used in the Medicare Promoting Interoperability (PI) Program to better align with evolving certification standards developed by the Office of the National Coordinator for Health Information Technology (ONC). These updates would revise or remove certain certification criteria that are proposed for elimination under ONC rulemaking, with the goal of maintaining consistency across federal health IT programs. The Department indicates that this approach would reduce duplicative or outdated requirements and support a transition toward more streamlined, interoperable digital systems.

CAFM and the AAFP support CMS and ONC’s ongoing collaborative efforts to ensure both agencies’ programs align requirements and timelines as much as possible. In our [comments](#) on the Health Data, Technology, and Interoperability: ASTP/ONC Deregulatory Actions to Unleash Prosperity (HTI-5) proposed rule, the AAFP said, “we would welcome CMS’ Merit-based Incentive Payment System (MIPS) aligning with ASTP/ONC to remove the same criteria in certification as will be finalized for removal in the forthcoming HTI-5 final rule.” As such, we support CMS’ proposal to revise the definition of CEHRT to align with ONC’s definition of CEHRT. **However, we do not agree that CMS should proceed with these changes if ONC does not finalize the identical provisions from the HTI-5 proposed rule. We believe aligning these definitions and criteria will reduce administrative burden for EHR developers and the physicians they serve, and we urge the agency not to move forward with these changes unless ONC finalizes the same provisions in the forthcoming HTI-5 final rule.**

4(b) Proposal to Remove the Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information Measures Beginning with the EHR Reporting Period in CY 2028

The Department proposes to remove the “Support Electronic Referral Loops by Sending Health Information” and “Support Electronic Referral Loops by Receiving and Reconciling Health Information” measures from the Health Information Exchange objective, beginning with the CY28 EHR reporting period. The Department indicates that removing these measures is part of a broader effort to streamline program requirements, reduce administrative burden, and transition toward more advanced, interoperable data exchange approaches.

Continuity of care is a hallmark of family medicine. While removing the measures would likely decrease administrative burden, continuity of care is critical to patient safety, improved outcomes, and lower costs. For primary care physicians to facilitate effective care coordination and continuity, they must both receive timely information from referrals and share relevant information with referring providers to support efficient, high-quality referral services. These measures have historically supported bidirectional exchange of clinical information during transitions of care, and their removal may reduce incentives to maintain these workflows in practice. We strongly encourage the Department to continue to find ways to incentivize continuity and care coordination.

5(e) Proposal to Require the Electronic Prior Authorization Measure Beginning with the EHR Reporting Period in CY 2028

The Department proposes to require reporting of the Electronic Prior Authorization measure beginning with the CY28 EHR reporting period. Under this measure, eligible hospitals and clinicians would attest to using CEHRT to submit at least one prior authorization request electronically for applicable medical items or services during the reporting period, unless an exclusion applies. The Department indicates that this requirement is intended to support broader interoperability goals by advancing the use of standardized electronic prior authorization processes, which are designed to streamline workflows, improve transparency, and reduce delays in patient care.

The AAFP opposes this proposal and has consistently opposed the addition of required measures under the Promoting Interoperability program. Prior authorization remains a significant administrative burden for physicians, and the purpose of electronic prior authorization application programming interfaces (APIs) should be to **improve** access to patient data, streamline workflows, and reduce that burden. If implemented effectively, these tools will drive wide, rapid voluntary adoption without the need for additional reporting requirements or associated penalties. Requiring this measure now risks adding administrative complexity before the underlying infrastructure is fully integrated into clinical workflows. **The AAFP encourages CMS to instead focus on ensuring these APIs are implemented in ways that are functional, reliable, and seamlessly integrated into CEHRT and physician workflows.**

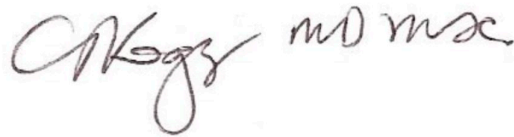
Conclusion

Thank you for your consideration of our comments. We look forward to continuing to work in partnership with CMS to advance policies that promote workforce stability, reduce administrative burden, and support the long-term sustainability of primary care training. As outlined throughout this letter, streamlining regulatory and reporting requirements will allow family physicians and training programs to focus on patient care and education rather than administrative complexity. We appreciate CMS' efforts to improve clarity and consistency across programs and encourage continued attention to policies that simplify processes while supporting high-quality, community-based training. Should you have any questions, please contact Nina DeJonghe, CAFM Director, Government Relations at ndejonghe@stfm.org and Mandi Neff, AAFP Senior Regulatory and Policy Strategist, Government Relations at mneff2@aafp.org.

Sincerely,



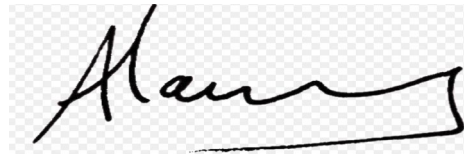
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