National Rural Health Association

December 8, 2025

The Honorable John Thune
Majority Leader
U.S. Senate
Washington, D.C. 20515

The Honorable Chuck Schumer
Minority Leader
U.S. Senate
Washington, D.C. 20515

The Honorable Mike Johnson
Speaker
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Hakeem Jeffries
Minority Leader
U.S. House of Representatives
Washington, D.C. 20515

Dear Majority Leader Thune, Minority Leader Schumer, Speaker Johnson, and Minority Leader Jeffries,

The National Rural Health Association (NRHA) writes regarding an urgent extension needed in order to enhance rural graduate medical education (GME) training. Section 131 of the Consolidated Appropriations Act of 2021 (CAA, 2021) provides eligible hospitals with a one-time opportunity to reset their low or zero Per Resident Amounts (PRAs) and Medicare full-time equivalent (FTE) resident caps. Hospitals had to meet specific criteria and submit requests by certain deadlines in order to qualify and **NRHA respectfully requests an extension of Section 131 to allow more rural hospitals to avail themselves of this opportunity.**

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

Historically, rural hospitals may have inadvertently triggered low or zero PRAs and/or FTE caps by allowing residents from outside programs to rotate at their hospital for a rural elective rotation. The Centers for Medicare and Medicaid Services (CMS) assigned these rural hospitals a "zero" PRA because they did not realize they were establishing themselves as teaching hospitals by accepting rotators and thus did not pay the training costs or report the residents on their cost report. Other rural hospitals established artificially low FTE caps deliberately by training a small number of residents and now cannot grow their program.

Congress intended to alleviate this issue by enacting Section 131 of the CAA, 2021 and allowing such hospitals to reset their low PRA or low FTE caps.[1] However, **NRHA remains concerned that many eligible rural hospitals have not and cannot utilize this opportunity because the timeline to request a reset is too narrow. The reset deadline sunsets on December 26, 2025.** There are **44 rural hospitals nationwide that are eligible for a reset under Section 131 yet only 2 have**

[1] "Category A" hospitals are those that established a PRA or FTE cap based on less than 1.0 FTE prior to Oct. 1, 1997. These hospitals may reset their PRA or FTE caps if they train at least 1 resident FTE. "Category B" hospitals are those that established a PRA or FTE cap based on 3.0 or fewer FTEs on or after Oct. 1, 1997, and before Dec. 27, 2020. These hospitals may reset their PRA or FTE caps if they train greater than 3 FTEs.

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availed themselves of this opportunity.[2] Even across all 219 eligible hospitals, only 23 have used Section 131 to reset their caps.[3]

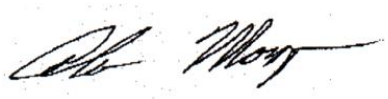
The small numbers suggest that the initial reset window was not long enough to facilitate a reset for most hospitals. The process is resource-intensive, particularly for hospitals that pursue an FTE cap reset as they must start a new residency program. This is even more of a challenge for rural hospitals that have less resources but still must identify or become a sponsoring institution, conduct community and stakeholder engagement, earn accreditation, recruit faculty and residents, and build the program curriculum. These steps significant upfront investment, both financially and in terms of time and personnel, both of which are barriers for rural hospitals.

Additionally, to take advantage of the reset opportunity, rural hospitals needed to be aware of both their low PRA and/or FTE caps and of the policy change in the CAA, 2021. Given the resources and time needed to reset these caps, no new rural hospitals realistically could have begun this process within the last two to three years of the Section 131 reset period. **NRHA supports another 5-year extension of this opportunity or fundamental reform to GME cap-setting to remove a cap building period for rural hospitals entirely.**

NRHA asks Congress to swiftly enact another 5-year extension, through December 2030, of the PRA and FTE cap resetting period first established in Section 131 of the CAA, 2021. This is a straightforward, short-term solution to growing the number of residents training in rural areas. NRHA also advocates for larger reforms around PRA and FTE caps that we encourage Congress to consider in the future, such as allowing rural hospitals to qualify for resets any time in the future or eliminating caps for all rural hospitals training 16 or fewer residents.[4]

Thank you for your dedication to protecting access to care in rural communities. NRHA looks forward to working with Congress to ensure rural GME programs grow and remain sustainable, ultimately increasing the number of rural physicians. If you have any questions or would like to discuss Section 131 further, please contact NRHA's Government Affairs and Policy Director, Alexa McKinley Abel (amckinley@ruralhealth.us).

Sincerely,



Alan Morgan
Chief Executive Officer
National Rural Health Association

Cc: Chairman Mike Crapo, Ranking Member Ron Wyden, Chairman Jason Smith, Ranking Member Richard Neal

[2] https://www.aamc.org/about-us/mission-areas/health-care/section-131
[3] *Id.*
[4] https://www.ruralhealth.us/getmedia/026186f4-c17e-43db-84fa-2fb3e43a3cdf/NRHA-Senate-GME-proposal-response-6-24-2024-final.pdf.

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