



September 24, 2026

The Honorable Markwayne Mullin
Secretary of Homeland Security
U.S. Department of Homeland Security
2707 Martin Luther King Jr. Ave. SE
Washington, DC 20528

The Honorable Joseph B. Edlow
Director
U.S. Citizenship and Immigration Services
5900 Capital Gateway Drive
Camp Springs, MD 20588

RE: Fee for Certain H-1B Petitions Notice of Proposed Rulemaking; RIN 1615-AD20; DHS
Docket No. USCIS-2026-0298

Submitted electronically via regulations.gov.

Dear Secretary Mullin and Director Edlow,

The National Rural Health Association (NRHA) is pleased to offer comments on the Department of Homeland Security's proposed rule, [Fee for Certain H-1B Petitions](#), which would impose an additional \$103,265 fee, payable at filing, on every H-1B cap-subject petition, including petitions eligible for the advanced degree exemption. NRHA is committed to working with the Administration to ensure that the needs of the more than 60 million Americans that reside in rural areas are supported by regulatory changes that strengthen, rather than erode, the health of rural communities. We look forward to our continued collaboration to improve health care access throughout rural parts of the United States.

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, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

NRHA recognizes the Department's responsibility to administer the nation's immigration system in an efficient and in a manner consistent with statute. However, we believe the proposed fee would create a substantial new barrier for rural health facilities already struggling to recruit and retain the professionals needed to maintain access to care. **We urge DHS to establish a clear, durable exemption from the fee for H-1B health care professionals who will furnish services in rural areas and to apply that protection across the full range of clinical and health care occupations on which rural communities depend.**

Rural communities face persistent shortages across the health care workforce. A broad range of health care facilities in rural areas rely on H-1B professionals to sustain primary and specialty care, diagnostic testing, rehabilitation, anesthesia coverage, nursing services, pharmacy services, behavioral health, and other essential care. These professionals can include physicians and dentists as well as advanced practice clinicians, physical and occupational therapists, medical and clinical laboratory technologists, pharmacists, researchers, and other specialty-occupation professionals. The truth of the matter is because domestic supply often does not meet needs in

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underserved communities, H-1B recruitment is not ancillary to rural care delivery. For many rural areas, it is one of the limited tools available to keep services accessible.

Physician data illustrate the rural reliance on H-1B professionals, but the access implications are broader. More than 11,000 physicians currently practice in the United States on H-1B visas,¹ and rural counties rely on H-1B physicians at nearly twice the rate of urban counties, while the highest-poverty counties rely on them at nearly four times the rate of the wealthiest counties.² Internationally trained clinicians are also more likely to serve Health Professional Shortage Areas, Medically Underserved Areas, and rural communities where shortages are most severe.³

The importance of these physicians will only increase in the years ahead. The U.S. already faces significant physician workforce shortages, with projections estimating a shortage of nearly 86,000 physicians within the next decade, with rural areas suffering disproportionately.⁴ U.S. medical schools do not currently produce enough physicians to meet the nation's future workforce needs. At the same time, demand for health care services continues to grow as the population ages and many currently practicing physicians approach retirement. **In many communities, particularly rural and underserved areas, internationally born and trained physicians are not simply part of the workforce, they are the workforce.**

The proposed rule would impose the \$103,265 charge in addition to all other applicable filing fees and payments and would require payment when the cap-subject petition is filed. DHS explains that the fee would recover a portion of government-wide immigration administration costs. However, the charge is not calibrated to an employer's size, operating margin, geographic market, payer mix, or ability to pass costs through. Rural providers typically have smaller recruitment budgets, lower patient volumes, and limited negotiating leverage, while Medicare, Medicaid, and other third-party payment rates generally do not adjust to absorb an extraordinary immigration fee. Nearly 50 percent of rural hospitals are currently operating with negative margins, and the median operating margin for rural hospitals is approximately one percent.⁵ For many rural employers, a single petition fee of this magnitude could exceed the practical value of the recruitment budget for the position.

Although some hospitals and other organizations may qualify as cap-exempt because of their institutional status or affiliation with an institution of higher education, that protection is uneven and does not resolve the rural access problem. Critical access hospitals, rural health clinics, rural long-term care providers, and rural hospitals without qualifying affiliations may remain exposed to the fee. Case-by-case relief would not provide the predictability rural providers need

¹ Liu M, Patel VR, Ramesh T, Vyas DA, Wadhera RK. [Health Care Professionals Sponsored for H-1B Visas in the US](#). JAMA. 2025 Dec 9;334(22):2035-2038. doi: 10.1001/jama.2025.20931. PMID: 41160415; PMCID: PMC12573110.

² Id.

³ Hailat R, Ridha M, Lin CC, Kerber K, Burke JF. [Trends in the Proportion of US and International Medical Graduates at the County Level](#). JAMA. 2025 Oct 14;334(14):1294-1295. doi: 10.1001/jama.2025.12818. PMID: 40810946; PMCID: PMC12355384.

⁴ GlobalData Plc. [The Complexities of Physician Supply and Demand: Projections From 2021 to 2036](#). Washington, DC: AAMC; 2024.

⁵ Chartis Center for Rural Health, Rural Hospital Closures & Care-Access Crisis: 2025 State of the State (Feb. 2025), <https://www.chartis.com/insights/2025-rural-health-state-state>.

to recruit for hard-to-fill positions and could itself create delay. A categorical exemption tied to rural service would be more administrable, more equitable, and better aligned with the Department's stated interest in distinguishing among petition categories when unique policy considerations warrant different treatment.

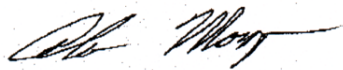
For these reasons, NRHA urges DHS to ensure that the final rule does not undermine rural health care access. Specifically, DHS should:

- **Establish a categorical exemption** from the proposed \$103,265 fee for cap-subject H-1B petitions filed for health care professionals who will practice in rural areas who will be employed by rural-serving hospitals, clinics, long-term care providers, community health centers, laboratories, rehabilitation providers, and other health care organizations.
- **Define eligible health care professionals broadly** to include physicians, dentists, clinical, diagnostic, rehabilitative, nursing, pharmacy, behavioral health, research, and other specialty-occupation roles necessary to sustain rural care.
- **Adopt a simple, prospective verification process** that gives rural employers certainty before filing and avoids case-by-case adjudication delays that can cause a candidate to be lost or a service gap to persist.
- **Continue improving H-1B processing and reducing administrative barriers** for health care professionals and rural-serving employers, and work with Congress on durable legislative solutions that strengthen the rural health workforce.

Every qualified health care professional who chooses to serve a rural community strengthens the local health care system. These professionals help preserve access to primary and specialty care, support rural hospitals and safety-net providers, reduce patient travel, and sustain rural communities and economies that depend on local health care. Policies that make rural recruitment financially infeasible ultimately harm patients and widen geographic inequities in access.

NRHA urges DHS to revise the proposed rule so that its revenue goals do not come at the expense of rural patients' access to essential care. A broad, categorical rural health care exemption—paired with predictable and efficient processing—would protect communities with the fewest workforce alternatives while preserving the Department's broader policy objectives. We appreciate the Department's consideration of these comments. If you have any questions, please contact Carrie Cochran-McClain, NRHA's Chief Policy Officer, at ccochran@ruralhealth.us

Sincerely,



Alan Morgan
Chief Executive Officer
National Rural Health Association