



March 10, 2026

Submitted via email: WMSubmission@mail.house.gov

House Committee on Ways and Means
Health Subcommittee
1139 Longworth House Office Building
Washington, DC 20515

Re: Statement for the Record on Advancing the Next Generation of America's Health Care Workforce

Dear Chairman Smith and Chairman Buchanan,

The National Rural Health Association (NRHA) appreciates the opportunity to submit this statement for the record on the recent Health Subcommittee hearing, Advancing the Next Generation of America's Health Care Workforce.

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.

NRHA appreciates the recognition of the need to bolster the rural healthcare workforce, particularly through reforming Medicare Graduate Medical Education (GME). We thank the Subcommittee and Committee leadership for focusing on this topic in its recent hearing. In response, NRHA submits the following policy priorities for the Committee's consideration.

1. Create new GME slots with a set aside for geographically rural hospitals.

The maldistribution of physician training, exacerbated by four rounds of Section 126 slot distributions, is a key concern of NRHA members. We commend Congress for creating 1,200 new GME slots through Sec. 126 of the Consolidated Appropriations Act (CAA) of 2021 and Sec. 4122 of the CAA, 2023 and including a set-aside in both slot creations for rural hospitals. However, a loophole in the language has allowed non-geographically "rural" hospitals that reclassified to rural status under a provision of the Social Security Act to take most of the 10% set-aside.¹

At the outset, the ability to reclassify was meant to aid rural hospitals that were grouped into a larger urban area or hospitals that treat a large share of rural patients. Reclassification remains an important tool for hospitals that fall into this category. However, from 2014 to

¹ 1886(d)(8)(E).

2022, the number of RRCs increased from 333 to 781.² One reason for this growth is the decision of the court in *Geisinger Community Medical Center v. U.S. Department of Health and Human Services (HHS)* in 2015, which held that hospitals could both convert from urban to rural for IPPS payment and simultaneously convert back to urban for wage index purposes.³ RRCs are classified as rural under 42 C.F.R. § 412.103. In 2014 the majority (213) of RRCs were rurally located.⁴ As of 2022 there were 208 rural RRCs and 573 urban RRCs.⁵ Overall RRC growth exploded in the eight-year period between 2014-2022, with the growth of urban RRCs substantially outpacing that of rural RRCs with the number of rural RRCs actually declined.⁶ The increase in RRCs suggests that urban hospitals receive benefits from the designation, from clinical payments to GME reimbursement, intended for those truly practicing and training in rural areas.

Analyses of the first four rounds of distribution of Sec. 126 slots and the distribution of the 200 Sec. 4122 slots show that reclassified urban hospitals have received more slots than geographically rural hospitals and likely “satisfied” the 10% set-aside because they are technically considered rural.⁷ In the fourth distribution round, 49 rural referral centers (RRCs) received Sec. 126 slots, 44 of which were reclassified and 2 of which were actually located in a rural area. In total, only 3 nonmetro, or geographically rural, hospitals received slots. The three previous rounds of distribution saw similar results.⁸

For future slot creations, NRHA suggests that Congress use a narrower definition of rural hospitals:

- Located in a rural area (as defined in section 1886(d)(2)(D)), excluding hospitals that are treated as being located in a rural area pursuant to section 1886(d)(8)(E);
- Are located in an area that has a rural-urban commuting code equal to or greater than 4.0;
- Are sole community hospitals (as defined in section 1866(d)(5)(D)(iii));
- Are located within 10 miles of a sole community hospital.

Congress could further consider adding a criterion that would capture hospitals with an accredited rural training track.

² Randall Longenecker & Lori Rodefild, *Rural track program funding: An erosion in definitions of rural places requires new action*, NATIONAL RURAL HEALTH ASSOCIATION, 2 (2022), https://www.ruralhealth.us/getmedia/f71ebd3b-543e-424e-8b7e-885d7c9d2a2f/NRHA-Policy-Paper-final-Rural-Reclassified-Hospitals-and-RTPs_1.pdf.

³ *Geisinger Cmty. Med. Ctr. v. Sec’y. U.S. Dept. of Health & Human Services*, 794 F.3d 383 (3d Cir. 2015); 42 C.F.R. § 412.230(a) (2023).

⁴ *Id.*

⁵ *Id.*

⁶ *Id.*

⁷ <https://nrha-prod-eastus-be.azure.silvertech.net/NationalRuralHealth/media/Documents/Advocacy/2026/CAA-Sec-126-R4-Analysis-02-09-26.pdf>

⁸ <https://www.ruralhealth.us/getmedia/bc5fd4e0-a96e-40f1-9183-d2b1753d17bd/CAA-Sec-126-R3-Analysis-1-18-25.pdf>, <https://www.ruralhealth.us/getmedia/4f1a622b-7328-4f24-8ba7-f4d9896dd712/CAA-Sec-126-Analysis-05-22-24.pdf>, and <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10413210/>.

Additionally, Sec. 4122 required that GME slots be awarded on a pro rata basis. We are concerned that another pro rata approach to distribution would discourage rural hospitals from applying for slots because they may not receive a full slot, or a full FTE, due to how slot equivalency is calculated. One slot covers the cost of training one resident for one year, only partially covering the residency. Thus, a fraction of an FTE is likely not enough incentive for rural programs to apply because the majority of costs associated with the resident training would not be funded by Medicare. Rural hospitals are less able to shoulder unfunded training compared to urban academic medical centers. For more information, please refer to NRHA's [fiscal year 2025 Inpatient Prospective Payment System \(IPPS\) comment](#).⁹

2. Authorize and invest further in the Rural Residency Planning and Development Program.

One hundred forty-five rural hospitals have been identified as strong candidates for starting a new residency program.¹⁰ Developing a new GME program typically takes 2 to 4 years and is significantly resource intensive. Hospitals must identify or become an ACGME sponsoring institution, conduct community and stakeholder engagement, earn accreditation, build the curriculum, and recruit a program director, faculty, and residents. This process requires significant upfront investment, both financially and in terms of time and personnel, both of which are barriers for rural hospitals.

Robust investment building rural capacity through the Rural Residency Planning and Development Program (RRPD), along with authorizing the program,¹¹ are important steps to encourage rural hospitals to take up physician training. NRHA underscores the importance and meaningful outcomes of RRPD to date as a pilot program. Rural hospitals often lack the resources to start up and maintain rural residency training programs. Since 2019, RRPD, housed in Federal Office of Rural Health Policy (FORHP) at the Health Resources and Services Administration (HRSA), has provided qualifying rural sites with \$750,000 over a 3-year period to help develop a new rural residency training program. RRPD has shown proven results since its inception.¹² As of March 2026, RRPD grantees have created 62 new accredited rural residency programs or rural track programs (RTPs), received approval for 752 new residency positions in rural areas, and enrolled over 660 resident physicians in rural clinical settings.¹³ These programs are in highly needed fields such as family medicine, internal medicine, psychiatry, and general surgery.¹⁴ Additionally, an analysis of training settings shows that Sole Community Hospitals (SCHs) and rural referral centers (RRCs) were

⁹ <https://www.ruralhealth.us/getmedia/fdb027e0-cd6e-42a6-8874-a965c1f8084e/NRHA-FY25-IPPS-comment-6-10-2024.pdf>.

¹⁰ Mukesh Adhikari, et al., *Characteristics of Hospitals by Graduate Medical Education Expense Category: Implications for Rural Residency Program Expansion*, 99 ACAD. MED. 567 (2024), <https://pubmed.ncbi.nlm.nih.gov/38060405/>.

¹¹ Rural Residency Planning and Development Act, H.R. 7855, 118th Cong. (2023) <https://www.congress.gov/bill/118th-congress/house-bill/7855>.

¹² Erin Fraher, et al., *Bolstering the rural physician workforce in underserved communities: Are Rural Residency Planning and Development Programs finding the sweet spot?* 39 J. RURAL HEALTH 521, 522, 526 (2022), <https://pubmed.ncbi.nlm.nih.gov/36566476/>.

¹³ <https://www.hrsa.gov/rural-health/grants/rural-health-research-policy/rrpd>

¹⁴ *Id.*

the most common sites followed by system-affiliated primary care clinics.¹⁵ Other safety net providers, like Critical Access Hospitals (CAHs) and Rural Health Clinics (RHCs) serve as RRPD training sites as well.¹⁶

NRHA recognizes that new slots and residency programs need interested candidates. We further encourage the Committee to work with the House Energy and Commerce Committee on solutions that would foster early interest in healthcare professions through existing programs like Area Health Education Centers.

3. Allow all rural hospitals to be paid equitably for training residents.

SCHs and Medicare-Dependent Hospitals (MDHs) are currently disincentivized from starting rural residency programs. SCHs and MDHs are paid at the greater of the federal rate (IPPS rate) or a hospital-specific rate. Those paid under the hospital-specific rate are not eligible to receive indirect medical education (IME) payments. SCHs and MDHs represent almost 80% of rural hospitals eligible to establish training programs but are disincentivized under the current GME payment framework.¹⁷ Equitable IME payments will help SCHs and MDHs currently training residents and those that are interested in starting a residency program.

NRHA asks that Congress amend § 1886(b)(3) to rebase and create a future fiscal year for SCHs and MDHs that develop or expand a residency program in a year after their hospital-specific rate was calculated.¹⁸ This would require removing estimates of IME, if any, from the hospital's base year and making the hospital eligible for IME payment adjustments in the same manner as other subsection (d) hospitals. This would ensure that the hospitals do not receive duplicate payments. At the same time, there must be explicit statutory language providing that these rural hospitals receive the full IME payment adjustment as hospitals paid under the federal rate.

4. Provide additional technical assistance for rural hospitals interested in GME.

As discussed above, NRHA recommends that Congress authorize the RRPD program through the Energy and Commerce Committee, given its considerable success in building residency training capacity in rural areas. Within the Committee's jurisdiction is the Medicare Rural Hospital Flexibility (Flex) program. The Flex program authority could be an additional vehicle to provide resources towards technical assistance (TA) and outreach regarding rural hospital residency training. Congress created Flex and Small Hospital Improvement Program (SHIP) as a bulwark against the structural challenges small rural hospitals face given their limited administrative capacity and resources. Annual Flex program funding provides infrastructure support that allows small rural hospitals to strengthen financial and

¹⁵ Fraher, *supra* note 31, at 524.

¹⁶ *Id.*

¹⁷ Alliance for Rural Hospital Access, *SCHs, MDHs Can Improve Rural Physician Shortages*, https://ruralhospitalaccess.org/wp-content/uploads/2023/05/PositionPaper_118thCongressTrainingPrograms_Sept2023Update.pdf.

¹⁸ *Id.*

operational performance and invest in activities that improve access to high quality care in rural areas. Strengthening rural hospitals is another solid investment to increase capacity for training in rural areas.

In addition, Congress should mandate that Centers for Medicare and Medicaid Services (CMS) provide technical assistance (TA) to rural hospitals that are interested in applying for new slot opportunities or starting a new residency program outside of RRPD. RRPD grantees already receive TA from the RRPD Technical Assistance Center run by the University of North Carolina.

5. Amend Medicare Rural Track Program eligibility to include FORHP rural areas.

Rural Track Programs (RTPs) are a partnership between an urban hospital and a rural site, such as a hospital, in which residents spend 50% or more of their time training at a rural site. Medicare provides GME funding to RTPs for training in nonmetro counties. However, given the diverse geography across the country, a more nuanced definition of rural should be applied. Many counties are large – especially in the western U.S. – and are considered metropolitan because they encompass a large city or urban core despite the outlying rural areas that are also encompassed in the county. Rural training sites in those areas are not eligible for Medicare RTP funding because they are in a metropolitan county. See below for an example from San Bernardino County where the dark green represents FORHP rural areas and light green is metro.



Medicare RTP eligibility should be aligned with the FORHP definition of rural, which includes rural census tracts that are located in metropolitan counties.¹⁹ This change would expand the number of rural hospitals eligible for Medicare RTP funding and in turn increase rural physician training opportunities.

6. Improve opportunities for rural hospitals to build “caps.”

Sec. 131 of the CAA, 2021, provided 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. The opportunity to begin a cap reset under this provision expired on December 27, 2025.

¹⁹ <https://www.hrsa.gov/rural-health/about-us/what-is-rural>.

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. 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.²⁰ 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 sunset on December 26, 2025. There were 44 rural hospitals nationwide that were eligible for a reset under Section 131 yet only 2 availed themselves of this opportunity.²¹ Even across all 219 eligible hospitals, only 23 have used Section 131 to reset their caps.²²

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 fewer 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 require significant upfront investment, 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, very few, if any, rural hospitals could have realistically begun this process within the last two to three years of the Section 131 reset period. Therefore, NRHA supports another 5-year extension of this opportunity. Alternatively, Congress could consider allowing rural hospitals with low caps to qualify for a PRA or FTE reset at any time.

Alongside this extension, NRHA also supports larger reform to cap building periods. Rural hospitals should be afforded a longer window for cap building by Medicare. Currently, hospitals have five years to build their “caps” or their FTE caps and PRA amounts. While this may capture the correct amount of time for urban hospitals, rural hospitals generally need more time to invest in and build their infrastructure. NRHA requests rural hospitals should have at least 10 years to build their caps.

²⁰ “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.

²¹ <https://www.aamc.org/about-us/mission-areas/health-care/section-131>

²² *Id.*



Thank you for the opportunity to comment on strengthening GME training in rural areas. The aforementioned policies would protect, sustain, and improve health care delivery for rural patients by strengthening the rural physician workforce. For additional information or to discuss these policies further, please contact NRHA's Government Affairs and Policy Director, Alexa McKinley Abel (amckinley@ruralhealth.us).

Sincerely,

A handwritten signature in black ink, appearing to read "Alan Morgan", is written over a light gray, textured background.

Alan Morgan
Chief Executive Officer
National Rural Health Association