



## **GME/T Legislative Committee Balanced Review** **Rural Teaching Hospital Relief Act of \_\_\_\_\_ (Draft)**

The intent of this review is to report direct and indirect impacts of proposed legislation, regulation or standards of accreditation on Graduate Medical Education (GME) that can reasonably be anticipated, for the purpose of informing policy, responding to requests for comment, and/or directing further work by GME Transformation and its members.

### **Section 1: Information**

- **Legislation Title and Bill Number:** Rural Teaching Hospital Relief Act of \_\_\_\_\_
- **Policy Category:** Workforce (GME slots, PRA), Rural
- **Date of Review:** December 29, 2025
- **Approved for sharing:** February 25, 2026

### **Section 2: Summary**

- **Brief overview:** The *Rural Teaching Hospital Relief Act of \_\_\_\_\_* establishes a minimum Medicare-funded cap of 16 full-time equivalent (FTE) residents and a national minimum Per Resident Amount (PRA) of \$175,000 (with annual CPI adjustments) for qualifying rural teaching hospitals. These provisions would take effect for cost reporting periods beginning on or after October 1, 2027, with the expectation of improving funding predictability and reducing administrative burdens for rural teaching hospitals, as well as strengthening the rural physician workforce pipeline.
- **Introduced by:**
- **Current status:** Not yet introduced, building a coalition

### **Section 3: Potential Impacts on GME (Positive (+) Negative (-) or Neutral (/))**

- **Direct:**
  - + Establishes a minimum Medicare-funded GME cap of 16 FTE residents for all eligible rural hospitals, eliminating existing small or inconsistent caps and providing a stable foundation for program growth.
  - + Sets a national PRA floor of \$175,000, indexed annually for inflation, with the goal of more consistent and equitable funding for rural residency training.
  - + Reduces administrative burden by simplifying cap-setting and PRA determination processes, which can be particularly beneficial for smaller, rural programs with limited staff and regulatory expertise.
  - + Prevents aggregation or redistribution of new cap slots, helping ensure that rural residency positions remain in rural communities rather than being absorbed into larger urban systems.



- **Indirect:**
  - + The PRA floor and increased predictability in funding may strengthen the financial stability of rural hospitals, supporting the long-term viability of residency programs.
  - + By expanding and stabilizing rural training capacity, the legislation has the potential to enhance the rural physician workforce pipeline, improving recruitment and retention in medically underserved areas.
  - Establishing a PRA floor would likely increase federal spending obligations, which could be a challenge for building support among legislators and may require offsets that would be detrimental to other established programs important to GME.

#### **Section 4: Next Steps for Board Consideration**

- **Proposed next steps (if any):**

Stakeholder impact outreach (collect perspectives from rural teaching hospitals and programs that would be affected) to help inform additional conversations with legislators.

We can discuss this at the next quarterly Legislative Forum in February so programs can have the opportunity to offer their assessments.
- **Priority Alignment:** High Priority