



March 10, 2026

The Honorable Vern Buchanan
Chairman
Health Subcommittee
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Lloyd Doggett
Ranking Member
Health Subcommittee
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Buchanan and Ranking Member Doggett:

On behalf of the American Academy of Family Physicians (AAFP), representing 124,500 family physicians and medical students across the country, I write in response to your recent Subcommittee hearing on February 24th entitled, *Advancing the Next Generation of America's Health Care Workforce*. The AAFP applauds the Subcommittee's interest in graduate medical education (GME) and the exploration of much needed reforms, especially as it relates to care in rural and underserved areas.

The AAFP has long been concerned about the shortage of primary care physicians in the U.S., particularly the supply of family physicians, who provide comprehensive, longitudinal primary care services for patients across the lifespan, including chronic disease management, treatment of acute illnesses, and preventive care. Primary care, of which family physicians represent a large percentage, is the only health care component where an increased supply is associated with better population health and more equitable outcomes. Studies have shown that more than 7,000 deaths could be averted in underserved areas through an increase in the number of primary care physicians.ⁱ

According to a December 2025 report from the Health Resources and Services Administration (HRSA), there will be a shortage of 70,610 primary care physicians by 2038, and this will be "particularly acute in nonmetro areas."ⁱⁱ In 2025, 7.3% of U.S. counties did not have a primary care physician and by 2036 rural communities will experience a 29% shortage of family physicians and a 39% shortage for all primary care physicians.ⁱⁱⁱ

Many factors are contributing to this ongoing shortage. Reported burnout, lower compensation, overwhelming administrative burden and complex patient populations for primary care clinicians play a role in these shortages. However, the current structure of traditional GME is fraught with issues that disproportionately affect rural areas and those pursuing primary care specialties. The majority of federal GME funding — approximately \$21.2 billion from Medicare in 2023 — is directed to large academic medical centers, even though a very small proportion of patients receive care in those settings.^{iv} Training in the community-based environments where most patients access care, receives comparatively limited and less stable funding.

The AAFP has previously provided [extensive comments](#) to Congress regarding the need to reform traditional GME. As your Committee works to improve the education and clinical training for future primary care physicians, especially for those in underserved and rural communities, the AAFP urges you to consider the following:

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- Improved allocation and geographic distribution of GME slots to support the recruitment of primary care physicians, especially in rural and underserved areas.
- Increased oversight and data collection on the success of GME programs in recruiting and retaining primary care physicians in rural and underserved areas, using the Robert Graham Center's "impact factor".
- Ensuring that GME funding for small, rural, and residencies in underserved areas matches the unique needs of those programs.
- Increased funding for programs that provide start-up funds to create new GME slots, especially where none currently exist or for those that want to expand programs in rural and underserved areas.
- Using the success of the Teaching Health Center GME program as a model for improving traditional GME for primary care.
- Supporting primary care residents, especially in rural areas, through student loan relief, physician support, and financial incentives.

Improved Allocation and Distribution of GME Slots

Many physician groups are advocating for a large overall increase in new GME slots. While the AAFP supports an overall increase in slots, we have not identified a specific number of slots needed to address the projected shortage of all physicians. However, [AAFP policy](#) is that effective health care systems should have a physician workforce that includes around 50% of physicians focused on primary care. Any legislation that aims to increase GME slots should therefore allocate at least 50% to primary care specialties. Additionally, the AAFP believes that the geographic distribution of slots – specifically for rural and underserved communities – should also be a key component of any GME reforms. Most physicians are trained at large academic medical centers in urban areas, and evidence indicates physicians typically practice within 100 miles of their residency program.^v As a result, the current distribution of GME slots has led to physician shortages that are particularly dire in medically underserved and rural areas.

The AAFP has [supported](#) policy proposals to modify the current definition of "rural hospitals" to better tailor the distribution of GME slots into truly rural areas. The AAFP believes that an updated definition of "rural" should align with other Centers for Medicare and Medicaid Services (CMS)-defined criteria (*all people and territory in an area with less than 50,000 people*) and that parameter should be used to allocate at least 10% of slots to rural hospitals, regardless of their Health Professional Shortage Area (HPSA) score. The AAFP appreciates the work that HRSA and other agencies have undertaken in recent years to promote health and health equity in rural and underserved communities, and we believe this change would better support their goals of delivering better care where patients most need it.

Further, the AAFP [strongly supports](#) the *Rural Physician Workforce Production Act (H.R. 1153)*, bipartisan legislation to strengthen the rural physician workforce by increasing opportunities for GME in rural communities. This legislation would bolster rural teaching hospitals by lifting outdated caps and removing Medicare limits on rural resident training growth, extending equitable federal GME funding to Sole Community Hospitals and Critical Access Hospitals,

and enhancing Medicare payment for urban hospitals that partner with rural facilities to provide resident training. The bill also establishes an elective per-resident payment initiative to ensure rural hospitals have the financial stability and resources necessary to expand residency programs and train the next generation of family physicians where they are needed most. We urge this Subcommittee to consider this legislation at a future markup of any GME reforms.

Measuring Success, Especially for Rural Residencies

The AAFP believes that data collection and appropriate metrics need to be utilized to accurately assess the successful recruitment and retention of primary care residencies, especially in rural and underserved areas. While we understand the historical reliance on a HPSA determination to help identify areas with the greatest need for GME slots, the AAFP believes that additional factors should be considered. While many residency training programs are located in HPSAs, the physicians training in these programs often do not go on to continue practicing in HPSAs. The current methodology used to determine the most effective distribution of GME slots, especially in an effort to increase access to care in rural and underserved communities, does not fully address the issue of retention. Prioritizing GME programs that train physicians who then continue to *practice* in HPSAs after completion of their training could allow us to use GME funding more efficiently and invest in programs with a track record of producing physicians who are more likely to fill existing gaps in health care access.

The [Robert Graham Center](#) (RGC), a research center that provides insights on primary care physicians and patients to ensure policy development reflects their unique needs, has developed an "[impact factor](#)," that the AAFP believes is more effective in ensuring that the majority of new GME slots are really reaching communities of need. This "impact factor" would add to the current methodology for determining the distribution and success of programs by measuring the retention of primary care physicians who choose to practice for extended periods of time in HPSAs. This would help ensure that the physicians trained through rural and medically underserved residencies go on to care for underserved populations. RGC, in partnership with AAFP, would be happy to work with Committee staff to assist with the development of methodology that would align with this "impact factor."

RGC recently unveiled the [GME-IQ](#) (Graduate Medical Education Impact Quotient), an objective, data-driven metric tool that measures the contribution of residency-sponsoring institutions to key health workforce goals. The tool assesses outcomes such as whether residency graduates remain in primary care and whether they ultimately practice in underserved or rural communities. The GME-IQ can assist researchers, health systems, and lawmakers in evaluating the real-world impact of residency programs on access to care. The tool can be used to explore the status of physicians across the country and among numerous specialties – including primary care, surgery, and psychiatry – to compare how effectively different institutions produce physicians who meet population health needs.^{vi}

The AAFP invites the Committee to explore the GME-IQ and would be glad to facilitate conversations between Committee and RGC staff. Use of this tool, with input from RGC, can assist with the development of GME reforms and help to inform strategic allocation of public

funding by highlighting programs that align training with the health needs of patients in rural and underserved communities throughout the nation.

Additional transparency and data are also necessary to ensure that GME slots are being utilized appropriately and most effectively for the communities they serve. The AAFP [supports](#) policies that would provide authority to the Secretary of Health and Human Services to utilize existing data and to collect any additional data necessary to determine that programs that seek "rural reclassification" are in fact operating in or serving rural areas. We continue to have concerns that rural reclassification can be inappropriately used by urban based hospitals that do little to serve the rural communities that acutely need access to primary care.

Full-Time-Equivalent Slots for Small, Rural, and Underserved Area Residencies

Resource constraints and funding uncertainties are two significant barriers that exist for all entities that wish to start new residency programs, but this is particularly acute for those in rural and underserved areas. Small, rural, and safety net hospitals all operate on extremely thin margins, and few have the financial resources to stand up an entirely new residency program without outside assistance. Additionally, residency slots are most often distributed as 1.0 full-time-equivalent (FTE) per fiscal year – with CMS sometimes even awarding fractional FTE positions. This is incredibly challenging, particularly for small and rural hospitals, as it introduces serious funding uncertainty and deters many programs from being able to expand.

While fractional FTE awards may be workable in large academic institutions where there are multiple funding options available, it would be a barrier for small residencies that do not have similarly deep resources. The AAFP would [strongly support](#) legislation that would align GME awards with program lengths, so that a hospital applying to train residents in a three-year program can request up to three FTE residents per fiscal year.

Additional Funding for Rural Residency Programs

Since its establishment in 2019, the Rural Residency Planning and Development (RRPD) pilot program has played an important role in addressing physician shortages in rural communities. The program supports the development and sustainability of rural residency programs which have become essential for training physicians in the communities and often will go on to practice in those same areas. RRPD funding helps cover key start-up expenses, including program development, accreditation, faculty training and resident recruitment, enabling more physicians to be trained in rural settings.

The AAFP, along with numerous other stakeholders, supports the *Rural Residency Planning and Development Act of 2025 (H.R. 6468)*, a bill led by Committee member Representative Carol Miller. This bill would authorize dedicated funding for the RRPD program and represents a critical step toward strengthening the rural physician workforce. Ensuring the continuation and expansion of this program will help build a sustainable pipeline of physicians prepared to serve rural and underserved communities. We applaud Representative

Miller for her leadership and strongly urge consideration of this legislation as any future Committee markup.

GME for Community-Based Settings

As stated previously, evidence shows that clinicians tend to practice where they train, and because most CMS-funded training occurs in hospital-based settings, many physicians pursue specialty care rather than community-based primary care. To better support the training of primary care physicians, congressional support for and expansion of the Teaching Health Centers GME (THCGME) program is key. The THCGME program is the only federal program that trains physicians and dentists in community-based settings with a focus on rural and underserved communities. After completing their training, THCGME graduates also work in underserved communities at higher rates than traditional GME graduates.^{vii}

To date, the THCGME program has trained more than 3,090 primary care physicians and dentists in community-based settings, of which 1,895 are family physicians.^{viii} Historically unstable and inadequate federal funding has created uncertainty for many THCGME programs over the years. This has resulted in the acceptance of fewer or no new residents for some programs and the lack of growth for others. In worse cases, some programs have closed. For these reasons, the AAFP cautions against short-term extensions for THCGME. The AAFP was [strongly encouraged](#) by the recent longer-term funding levels that were included for THCGME in the *Consolidated Appropriations Act (CAA) of 2026*. **Congress should work toward a permanent and robust funding solution for THCGME programs, but at the very least should ensure that short-term funding patches do not occur in the future. Consistent funding for these programs provides a foundation for continued success in recruiting and retaining primary care clinicians in communities that need them most. The AAFP would also welcome specific GME reforms that would direct Medicare funding specifically to community-based residency programs.**

Financial Incentives to Support Primary Care Residents

While not squarely within this Committee's jurisdiction, we would be remiss not to mention the impact that student loan debt has on the development of our health care workforce. We have [long supported](#) the *Resident Education Deferred Interest (REDI) Act* (H.R. 2028), bipartisan and bicameral legislation, because family medicine resident salaries average \$59,430 per year, while their average student debt load is more than triple that amount and accrues interest rapidly.^{ix} Residents who experience a substantial increase in their loan debt, simply as a result of the interest they accrue while receiving their required training, are also less likely to remain in rural and underserved areas after their training concludes because of the need to seek higher paying salaries to mitigate that ever-growing debt.

The AAFP recommends passing the *REDI Act* as written to mitigate at least a small portion of the financial burden family physicians and others accrue while they are completing their medical training.

Research has shown that loan forgiveness or repayment programs directly influence physician practice choice. The rising level of educational debt disproportionately affects underrepresented and low-income students and limits their representation in the health workforce. Reducing student debt can help reduce physician shortages, particularly in rural and medically underserved communities. Mitigating student debt also frees up capital for family physicians who wish to pursue independent practice. In addition to expanding funding for federal loan repayment programs, any loan repayment funds received from these repayment programs should not be subject to federal income tax. This could provide an additional incentive for physicians to participate in them. The AAFP supports legislative efforts to exempt federal loan repayment programs from taxable income, including the [Strengthening Pathways to Health Professions Act \(H.R. 593\)](#), a bipartisan bill that would exempt some HRSA loan repayments from taxable income.

Finally, the AAFP also supports tax credits for medical residency preceptors. Preceptors provide a one-on-one relationship with a resident to help the student develop the needed clinical skills and practical experience working with patients. Preceptors are usually not members of a school or residency program's faculty but are often practicing clinicians at clinical sites or in some cases, private offices, which are often the most valuable type of preceptorship.^x However, many preceptors are concerned about increased time commitments from teaching that take them away from their patients, leading to lower productivity in their role as physicians. It is especially important to attract preceptors to residency programs located in rural districts. That is why the AAFP has supported the [Rural Health Preceptor Tax Fairness Act](#), a bipartisan bill from last Congress that would provide a \$1,000 tax credit to preceptors in health professional shortage and rural areas. We strongly support the reintroduction of this bill and encourage the Committee to move this legislation forward.

Thank you for the opportunity to provide this feedback and for championing long-overdue reforms to our nation's GME system. The AAFP looks forward to partnering with you on efforts that will successfully train a sufficient supply of family physicians to care for patients in every community across the country. If you have any questions, please contact Megan Mortimer, Manager of Legislative Affairs at mmortimer@aafp.org.

Sincerely,

A handwritten signature in black ink that reads "J Brull, MD". The signature is written in a cursive, flowing style.

Jen Brull, MD, FAAFP
American Academy of Family Physicians, Board Chair

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- i [Increasing Primary Care Physicians Could Boost Life Expectancy, Reduce Deaths in Underserved Areas - American Board of Family Medicine](#)
- ii [State of the Primary Care Workforce, 2025](#), Health Resources and Services Administration, December 2025.
- iii [State of the Primary Care Workforce, 2025](#), Health Resources and Services Administration, December 2025.
- iv [Medicare Graduate Medical Education, 2025 | Congress.gov | Library of Congress](#)
- v [Proximity to Residency Training Programs Still Matters for Practice Location | Annals of Family Medicine](#)
- vi [Microsoft Word - NASEM GME Discussion Paper Final 1.27.26](#)
- vii [Investing in Primary Care: The Missing Strategy in America's Fight Against Chronic Disease](#)
- viii [Teaching Health Center Graduate Medical Education \(THCGME\): Expanding the Primary Care Workforce | Bureau of Health Workforce](#)
- ix [Physician specialty: Family medicine | American Medical Association](#)
- x [Faculty Development for Community Preceptors: a Narrative Review of the Literature - PMC](#)