AMERICAN ACADEMY of FAMILY PHYSICIANS

July 15, 2025

The Honorable Morgan Griffith
Chairman
Subcommittee on Health
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Diana DeGette
Ranking Member
Subcommittee on Health
House Energy and Commerce Committee
2322A Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Griffith and Ranking Member DeGette:

On behalf of the more than 128,300 family physicians and student members of the American Academy of Family Physicians (AAFP), we would like to encourage the Committee to consider additional legislative and policy proposals for your upcoming hearing, "Legislative Proposals to Maintain and Improve the Public Health Workforce, Rural Health, and Over-the-Counter Medicines."

The U.S. faces a critical family physician workforce shortage, which has led to disparate access to care for patients nationwide and disproportionately affects rural and underserved communities. The AAFP encourages the Committee to consider policies that reimagine our country's recruitment, training and retention of primary care physicians in these areas. This will bolster our primary care workforce for the future and allow us to realize the true value of primary care for generations to come, including significant cost savings and improved patient outcomes as we shift toward a system that prioritizes health care, rather than sick care.

We appreciate that reauthorization of Title VII programs administered by the Health Resources and Services Administration (HRSA) is on the docket for this hearing. For decades, Title VII programs have played an integral role in our nation's primary care physician training. The legislation specifically seeks to reauthorize programs that the Academy has long supported, such as Primary Care Training and Enhancement (PCTE), Area Health Education Centers, and scholarships and educational assistance for individuals from disadvantaged backgrounds. Unfortunately, the Department of Health and Human Services (HHS) proposed budget aims to cut all funding for PCTE and Medical Student Education programs. We urge the Committee to continue to not only reauthorize these essential programs but to champion them in discussions with the Administration.

As you consider continuation of these essential workforce programs, the AAFP also strongly encourages the Committee to prioritize continuation and expansion of other primary care workforce programs with approaching expirations. We also urge advancement of other proposals within the Committee's jurisdiction that would bolster the primary care workforce and expand access to care, particularly in rural communities. The AAFP welcomes the opportunity to work with you to support future hearings and markups that would address these issues that we discuss below.

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Further, the Committee must act before September 30 to reauthorize, and should provide increased funding for, community health centers (CHCs), including federally qualified health centers (FQHCs) and rural health clinics (RHCs). Primary care physicians make up nearly 90 percent of physicians working in CHCs, and most of those physicians are family physicians. [i] Not only are CHCs often the only primary care access point in communities, but they serve as a natural hub for primary care physician training as well. To ensure every American has access to comprehensive primary care, we look forward to partnering with you to invest in both CHCs and the programs that help embed family physicians within them, as further described below.

Physician Education and Training in Rural Areas

Teaching Health Center Graduate Medical Education

Evidence indicates that physicians typically practice within 100 miles of their residency program, meaning that the current distribution of trainees in large academic hospitals also leads to physician shortages in medically underserved and rural areas. These shortages result in access barriers and disparities in health outcomes for patients living in these communities.

Currently, the Teaching Health Center Graduate Medical Education (THCGME) program is one of the only federal programs that train residents in a community-based outpatient setting. To date, the THCGME program has trained more than 2,027 primary care physicians and dentists in community-based settings, 61 percent of whom are family physicians.[ii] In the 2023 – 2024 academic year, the program funded the training of over 1,096 residents in 81 community-based residency programs.

THCGME programs have also been proven to increase patient care in underserved communities. A 2024 evaluation of THCGME programs found that over a five-year period (academic years 2018-2023), residents provided care to nearly 3.9 million patients and 85 percent of the 1,059 residents who graduated and provided employment data worked in a medically underserved community.[iii] However, even with these measured successes, permanent or long-term funding for THCGME programs does not currently exist. This funding uncertainty only undermines the programs, delays the creation of new primary physician training programs, and has also led to some program closures.[iv]

The AAFP continues to support legislative efforts that would *permanently* authorize the THCGME program such as the Doctors of Community (DOC) Act. However, absent a permanent solution, we urge Congress to, at a minimum, provide a multi-year reauthorization that provides sufficient funding levels to support the true per-resident costs to each program. We were encouraged by the funding levels and five-year authorization for THCGME that were included in the latest bipartisan year-end health care package, but were disappointed when that bill was defeated by outside influence. We urge the Committee to consider this proposal as a floor moving forward in reauthorization efforts. Supporting THCGME, in conjunction with comprehensive reforms to traditional graduate medical education programs, is one of the only ways to ensure a robust primary care workforce and increase access to care in rural and community-based settings.

Traditional Graduate Medical Education Reforms

The AAFP believes substantial reforms to traditional graduate medical education (GME) are necessary to support an adequate national primary care workforce, especially in rural communities. The AAFP holds that effective health care systems should have a physician workforce comprised of around 50 percent primary care physicians. While we have been encouraged by some legislative proposals that would allocate 25 percent of GME slots for primary care physicians, we would encourage an even larger percentage to further mitigate the primary care physician shortage that many areas of the country are already experiencing or will soon be.

Additionally, while the Academy appreciates the intent of some legislative proposals to increase distribution of new GME slots to rural and underserved areas, they still rely heavily on a Health Professional Shortage Area (HPSA) designation to determine allocation. 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.[v] In addition, not all HPSAs have residency training programs located in them and therefore basing distribution of residency slots based solely on a HPSA determination is limiting. Ultimately, the current methodology for GME slot distribution is not meaningfully increasing the workforce in rural and underserved communities. Instead, GME funding could be used more efficiently by investing in programs with a track record of producing physicians who are more likely to fill existing gaps in health care access – such as those programs that train physicians who then continue practicing in HPSAs after residency.[vi]

To achieve this aim and more effectively train and distribute primary care physicians across the country, the AAFP urges the Committee and your colleagues in Congress to:

- **Require the Centers for Medicare and Medicaid Services (CMS) to utilize the AAFP's "impact factor".** This is one way that Congress could ensure that the majority of new GME slots are really reaching communities of need. This "impact factor" would be added to the current methodology for awarding GME slots and prioritize applications for programs where a higher proportion of trainees ultimately go on to practice in HPSAs.

- **Create a new GME council specifically focused on the retention of physicians in HPSAs and medically underserved communities.** This council should utilize existing and new collection of data that would then be incorporated in any updated methodology used to determine the allocation and prioritization of GME slots. This would help ensure that the physicians trained through rural and medically underserved residencies go on to care for underserved populations. The Academy would be happy to work with Committee staff to assist with the development of this methodology, especially if it aligns with the AAFP's "impact factor."

- **Update the current GME program definition of rural (all people and territory in an area with 100,000 people) to align with other CMS-defined criteria (all**

people and territory in an area with less than *50,000* people) and use that parameter to allocate at least 10 percent of slots to rural hospitals, regardless of their HPSA score. Further, we support legislative efforts that aim to diversify the physician workforce by prioritizing slots at hospitals with an affiliation with a historically black college or minority serving institution. The Academy has long supported policies that aim to diversify the health care workforce. Evidence has shown that students from backgrounds currently underrepresented in medicine are more likely to care for underserved populations in their careers and are more likely to practice primary care.[vii]

- **Eliminate the cap on residency slots for programs serving rural and underserved communities.** The AAFP supports increasing the cap for GME slots, but we believe that capping slots for all programs at a specific number is not the most effective way to increase access to care through these programs. We would encourage increasing the cap for most hospitals, and have no caps for programs serving rural and underserved communities. Given the data that illustrates the direct correlation between where a physician trains and ultimately decides to practice, removing the cap for GME programs located in rural and underserved areas (as we have defined above) would create more opportunities for physicians to continue practicing in those areas beyond their training. The AAFP supports a bill that would remove the caps on rural hospitals specifically. Rural Physician Workforce Production Act, a bill that would remove the caps on rural hospitals specifically.

- **Codify the Rural Residency Planning and Development (RRPD) program,** which is intended to help address rural GME distribution disparities by supporting the creation and sustainability of rural residency programs. Funding from this program is crucial for training and retaining health care clinicians in rural areas and helps to cover start-up costs, accreditation, faculty development, and recruitment, and it expands the number of trained physicians in rural settings. We have supported legislation to support the codification of this program in statute and continue to urge its enactment.

Supervision of Primary Care Residents

This Committee has the opportunity to advance policies that would meaningfully reform supervision requirements for primary care residents, thus improving both physician bandwidth and patient care. Specifically, the Academy continues to advocate for residents permanently being permitted to provide care via telehealth with the same level of supervision from the teaching physician as occurs during their in-person office visits.

Additionally, the AAFP supports the expansion of allowable services under the Primary Care Exception (PCE). The PCE permits a teaching physician to bill for certain lower and mid-level evaluation and management (E/M) services furnished by residents in certain types of residency training settings, even when the teaching physician is not present with the resident, if certain conditions are met. These flexibilities would afford teaching physicians – especially

those that travel great distances in rural communities – more time to train additional residents and to focus their training on more complex and in-depth services.

By allowing all levels of E/M services under the primary care exception, CMS will support primary care workforce development and improve patient continuity of care without compromising patient safety. Further, including additional preventive services in the PCE services list will increase utilization of high-value services.

The AAFP has submitted extensive comments to CMS highlighting research that supports these changes and also names the specific codes that should be allowed under the PCE. Unfortunately, CMS did not take steps to enact these changes in the proposed rule for the Calendar Year 2026 Medicare Physician Fee Schedule that was released yesterday. **Therefore, we urge congressional support for these changes and, if necessary, legislative action to achieve these changes should CMS not pursue them on its own.**

While the AAFP is encouraged by the Committee's commitment to exploring policies that support the health care workforce, especially in rural areas, we believe additional hearings must be held soon to fully address the multi-pronged approaches necessary to ensuring robust access to care for all patients.

Family physicians, residents and medical students interested in primary care are facing more uncertainty than ever before – uncertainty that will manifest in worse access to care for patients. Right now, physicians and students are experiencing:

- Continued cuts to Medicare payments;
- Reduced access to federal financial support to pursue a medical degree;
- An unrelenting barrage of administrative and paperwork burden that is severely limiting their time for patient care;
- Threats to the very existence of loan repayment programs that disproportionately impact primary care physicians;
- Policies that interfere with the physician-patient relationship; and
- Inconsistent, unpredictable funding for primary care workforce programs and care settings.

This is creating a regulatory and policy environment that not only deters prospective physicians from pursuing primary care, but threatens the viability of our nation's primary care infrastructure altogether. The AAFP appreciates the Committee's holding this hearing, and we look forward to working with you to advance the recommendations outlined above to ensure that primary care remains accessible, both for the patients who need it and the individuals hoping to pursue it as a career. Should you have any questions, please contact Natalie Williams, Senior Manager, Legislative Affairs, at nwilliams2@aafp.org.

Sincerely,

AMERICAN ACADEMY of FAMILY PHYSICIANS

Steve Furr, M.D., FAAFP

Steve Furr, MD, FAAFP
American Academy of Family Physicians, Board Chair

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[ii] Teaching Health Center Graduate Medical Education (THCGME): Expanding the Primary Care Workforce | Bureau of Health Workforce
[iii] https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/thcgme-eval-nchwa.pdf
[iv] [i] https://kffhealthnews.org/news/article/physician-teaching-health-centers-funding-instability-underserved-areas/
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[vi] Migration after family medicine residency: 56% of graduates practice within 100 miles of training - PubMed
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