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Advancing Health in America

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Statement

of the

American Hospital Association

for the

United States House of Representatives

Committee on Ways and Means

Subcommittee on Health

"Advancing the Next Generation of America's Health Care Workforce"

February 24, 2026

On behalf of AHA's nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to share the hospital field's perspective on advancing the next generation of America's health care workforce.

We appreciate that the subcommittee is working to improve this vital issue, including the importance of Medicare's graduate medical education (GME) program in addressing physician shortages, particularly in rural and underserved areas of the nation. We stand ready to work with you to formulate legislation to address these shortages, promote the highest quality training, and ensure that patients can access the health care services they need.

Physician Shortages

Across the nation, hospitals and health systems, and the patients we serve, experience daily the strain of health care workforce shortages. According to data from the Association of American Medical Colleges, physician shortages are projected to exceed 86,000 by 2036, including severe shortages of primary care physicians and specialists, such as pathologists, neurologists, radiologists and psychiatrists. Because a talented,

qualified, and engaged workforce is at the heart of America's hospitals and health care systems, our members' capacity to deliver high-quality care depends on attracting and retaining a well-trained physician workforce. These shortages — combined with an aging population, a rise in chronic diseases and behavioral health conditions, physician burnout and "state-of-the-art" care delivery advancements — all contribute to a need for robust GME funding to appropriately staff hospitals, prepare physicians for the health system of the future and ensure continued access to care.

The Federal Role in GME

Congress created the Medicare GME program to cover Medicare's proportion of the costs of a hospital's approved medical residency program, including the direct costs of operating the program, such as resident stipends, supervisory physician salaries and administrative costs. Medicare GME payments also cover the indirect costs associated with residency programs, which may result in higher patient care costs in teaching hospitals relative to non-teaching hospitals. For example, resident-provided care may be more expensive because of additional tests residents may order as part of their training and the additional time required to perform certain procedures in a training setting. However, for direct GME (DGME) or indirect medical education (IME), Medicare's payment is not intended to reflect the hospital's full cost of training a resident. Other sources of GME funding include state Medicaid programs, the Veterans Health Administration, and the Health Resources and Services Administration (HRSA), children's hospitals and Teaching Health Centers.

The Balanced Budget Act of 1997 and Subsequent Legislation

In response to predictions of a surplus of physicians, Congress froze the number of Medicare-funded physician training slots at 1996 levels under the Balanced Budget Act of 1997 and set limits on how many residents hospitals could count for certain payments. Since then, if hospitals wanted to expand their residency programs, they had to pay for extra residents themselves. Nearly three decades later, this law still restricts hospitals from training more providers and has played a role in current shortages of doctors, particularly in primary care, behavioral health, and general surgery. The resident caps continue to hinder efforts to address these shortages. Through the Consolidated Appropriations Acts of 2021 and 2023, Congress created 1,200 additional Medicare-funded slots, prioritizing rural and underserved communities, hospitals in states with new medical schools, institutions operating over their existing caps, and those focused on primary care and behavioral health.

Addressing Workforce Challenges in Rural Communities

The nation's more than 1,700 rural hospitals — about 35% of all hospitals — are the heart of health care for rural America. These organizations are deeply committed to providing local, affordable and high-quality care. More than 57 million Americans in rural communities depend on their hospital as a vital source of health care and as a critical

component of their area's economic and social framework. However, several ongoing challenges continue to jeopardize the stability of rural hospitals.

Rural hospitals face similar difficulties to those experienced by many other hospitals — including financial stress and inadequate reimbursement from governmental and private payers. But rural hospitals face additional unique hurdles. For example, their patient mix makes them more reliant on public programs and, therefore, more vulnerable to cuts and underpayments in Medicare and Medicaid.

Further, nearly half of rural hospitals have 25 or fewer beds, with just 16% having more than 100 beds. Given that rural hospitals tend to be much smaller, patients with higher acuity often travel or are referred to larger hospitals nearby These hospitals handle lower patient volumes, making it more difficult to support essential health services; they face higher operating costs for supplies and transportation; and they must work harder to recruit and retain health care professionals to live and work in remote areas.

Perhaps the most persistent challenge is in professional recruitment and retention, which present disproportionately high barriers and expenses for rural hospitals. In fact, nearly 70% of the federally-designated primary care health professional shortage areas (HPSAs) are located in rural or partially rural areas.

Increasing the Number of Physicians Training in Rural Areas

Congress should support and expand targeted programs that help mitigate workforce shortages in rural communities. We are aware of concerns that rural hospitals have received fewer residency slots in recent distributions. We encourage rural hospitals to fully participate in the GME program. According to the Centers for Medicare & Medicaid Services (CMS), across the four rounds of Section 126 distributions, rural hospitals submitted 2.9% of applications and received 3.3% of slots.

The AHA is committed to working with Congress to assist rural hospitals with any financial, regulatory or administrative burdens that prevent them from applying for or receiving GME slots.

At the same time, hospitals exploring the establishment of *new* residency programs, which are not subject to the Balanced Budget Act of 1997 caps, confront daunting challenges. A new residency program can take approximately two years to establish, and start-up costs can be prohibitive — requiring resources that small rural hospitals cannot afford, given their financial constraints. HRSA's Rural Residency Planning and Development Program, which provides start-up funding to rural hospitals to create new residency training programs in rural areas, funded $77 million in awards between 2019 and 2025 to establish 62 new accredited rural residency programs, created 752 approved new residency positions in rural areas and enrolled over 660 resident physicians to train in rural settings. These data speak to the fact that starting a new residency program in rural settings is challenging, and much of the need exists in

helping rural providers start these programs so they can apply for residency slots to sustain their programs once started.

While the aging of the U.S. population and the physician workforce drive some of the projected shortage, much of it stems from the caps on Medicare-funded residency slots. Furthermore, the caps have created imbalances that favor slot allocation toward lower-cost and higher-reimbursement specialties, rather than more urgently needed areas of concentration, like primary care.

Graduate Medical Education. We urge Congress to enact the Resident Physician Shortage Reduction Act of 2025 (H.R. 4731/S. 2439), bipartisan legislation that would lift existing caps on the number of Medicare-funded physician residency slots and fund 14,000 new slots over the next seven years, introduced by Reps. Terri Sewell, D-Ala., and Brian Fitzpatrick, R-Pa. Passage of this legislation would help alleviate physician shortages in rural and other underserved areas and improve patients' access to care. Lifting the cap on Medicare-funded residency positions would enhance access to care and help America's hospitals better meet the needs of the communities they serve. It would provide hospitals more flexibility to diversify and maintain training programs, including both primary care and specialty programs. In addition, an increase in slots would allow health systems to train residents in more diverse facility types, such as smaller rural hospitals, that may not have the capacity to operate their own training programs. This would benefit both the quality of physician education and the patients they would serve. We also support robust funding for rural residency track programs, which provide medical residents with additional training opportunities in rural areas.

Conrad State 30 Program. We urge Congress to pass the Conrad State 30 and Physician Access Reauthorization Act (H.R. 1585/S. 709) to reauthorize and expand the Conrad State 30 J-1 visa waiver program, which waives the requirement for physicians holding J-1 visas to return home for a period if they agree to stay in the U.S. for three years and practice in federally designated underserved areas.

Loan Repayment Programs. We urge Congress to pass legislation to provide incentives for clinicians to practice in rural HPSAs. We support expanding the National Health Service Corps and the National Nurse Corps, which incentivize health care graduates to provide health care services in underserved areas.

Visa Recapture. We urge Congress to pass the Healthcare Workforce Resilience Act (H.R. 5283/S. 2759/) to recapture up to 40,000 unused employment visas for foreign-trained workers (25,000 for nurses and 15,000 for physicians).

Additionally, we support **HRSA's Teaching Health Center Graduate Medical Education Program**, which augments the primary care workforce by supporting primary care and dental residency programs and promoting opportunities for residents to provide care to rural and other underserved communities.

The AHA also supports efforts to encourage qualified applicants from rural and other underserved areas to become physicians, such as the Rural and Underserved Pathway to Practice Training Programs that would establish medical school scholarships and stipends for these students. The program would incentivize students to become physicians and to practice in those communities, helping to alleviate severe shortages in those areas.

Rural Reclassification Policy

In the Balanced Budget Refinement Act of 1999, Congress included a provision permitting hospitals in urban areas to reclassify as rural if they meet certain criteria. This dual classification permits eligible hospitals to be urban for certain payment purposes and rural for other payment purposes. For example, reclassified hospitals receive an increase in their IME resident training caps. Those hospitals' existing caps on direct GME residency slots remain unchanged. Therefore, these hospitals are not eligible for an increase in Medicare-funded residency positions.

Conclusion

The AHA appreciates your consideration of these key issues as you examine the future of the health care workforce. Improvements in federal programs, including Medicare GME, can bolster our nation's physician workforce, and those proposals have strong bipartisan support. We stand ready to work with you in a bipartisan manner to bolster and expand the physician workforce, the hospitals that train it, and the communities that depend on it for care.