



Feb. 24, 2026

## **House Ways and Means Committee Hold Hearing on the Next Generation of America's Health Care Workforce**

### *Overview:*

On Feb. 24, the House Ways and Means Subcommittee on Health held a hearing on advancing the next generation of America's health care workforce. Witnesses included representatives of graduate medical education (GME) training centers, rural hospitals, schools of medicine, and provider associations. The hearing primarily centered on identifying and reversing the drivers of health provider shortages, particularly in rural or underserved areas. Witnesses spoke to the challenges that small and rural community health centers face in recruiting new practitioners, establishing new residency and training programs, and acclimating to a policy framework that is both archaic in some instances, yet everchanging in others. For example, the nationwide cap on Medicare-funded physician residency slots implemented by Congress in 1997 remains stagnant today, while new changes such as health care funding cuts in the One Big Beautiful Bill Act add uncertainty to the livelihoods of health care practitioners. While a majority of questions and answers related to the physician workforce, many of these themes extend to the experience of other health care providers, including pharmacists.

Last year, AMCP published its inaugural [Managed Care Pharmacy Workforce Survey report](#). The findings included in this report explore three primary areas, individual and organizational demographics and job functions, compensation information, and professional satisfaction. In relation to the challenges of rural provider shortages, only 2.7% of survey respondents reported living in rural areas. As with other medical professions, many of the managed care pharmacists surveyed reported experiencing burnout or physical and emotional exhaustion at work. These results stress the need for policy solutions that direct new practitioners and resources to underserved areas while protecting the wellbeing of pharmacy professionals already in the workforce. The \$200,000 lifetime borrowing cap on federal graduate student loan support [included as part of the One Big Beautiful Bill Act](#) also limits the development of new medical practitioners, by either driving them towards predatory private education loans or away from the medical profession altogether.

### *Witnesses:*

- Dr. Emily Hawes, Professor, University of North Carolina at Chapel Hill, and Director, Sheps Graduate Medical Education Technical Assistance Center Chapel Hill, North Carolina
- Jason Shenefield, Chief Executive Officer, Phelps Health
- Dr. Thomas Mohr, D.O., Dean, Sam Houston State University College of Osteopathic Medicine
- Dr. Jennifer Trilk, Ph.D., Director, Lifestyle Medicine, University of South Carolina School of Medicine Greenville, and Co-founder and Director of Lifestyle Medicine Education
- Dr. Andrew Racine, President, American Academy of Pediatrics

*Committee Leadership:*

- Full Committee Chair – Jason Smith (R-MO)
- Full Committee Ranking Member – Richard Neal (D-MA)
- Health Subcommittee Chair Vern Buchanan (R-FL)
- Health Subcommittee Ranking Member – Lloyd Doggett (D-TX)

*Question & Answer Highlights:*

Rep. Adrian Smith (R-NE) – Dr. Hawes, you mentioned success of HRSA's rural residency program. How challenging is it to start up a new rural residency program and how does this funding help?

Dr. Hawes – It requires substantial upfront costs by negotiating funding agreements, construction plans, staff salaries etc. Sustainable Medicare GME reimbursement is the hinge that determines whether these programs grow.

Rep. Smith (NE) - How would codification of the RRPD increase number of residency programs?

Dr. Hawes – There are other 700 rural facilities that haven't engaged in GME. This is untapped potential and opportunity. RRPD actually funds technical assistance that drives policy solutions. It also shows that rural training is possible, providing startup funding and technical assistance that Medicare GME does not.

Rep. Smith (NE) – What is the single greatest challenge in recruiting a physician to a rural facility?

Mr. Shenefield – The need has gotten greater, and the availability of physicians has gotten fewer. In rural America, it's difficult to get providers to come to your community and feel connected to it.

Rep. Mike Thompson (D-CA) – Did the trillion dollar Medicaid cut help or hurt rural health delivery?

Dr. Hawes – GME is funded through multiple sources. A change in one will affect the whole system.

Mr. Shenefield – Payment sources have been a challenge for every year of my career.

Dr. Racine – It hurts.

Rep. Thompson – Secretary Kennedy is undermining health care in America with his decisions on vaccines. Do vaccines save lives? Can you talk about the struggles pediatricians are facing in combating misinformation?

Dr. Racine – Unequivocally. Uncertainty in this area has caused a great deal of harm for pediatricians. Many patients are misinformed and others are concerned they can't access vaccines, while pediatricians are concerned with liabilities around providing vaccines.

Chairman Jason Smith (R-MO) – My main priority is expanding access to care in rural America. These are the communities I represent, every hospital I represent is a rural hospital. How is Phelps Health developing its family medicine residency program and how the Medicare program can make it easier to innovate?

Mr. Shenefield – We had discussed doing a residency program for years, but the challenge was funding. As far as funding, the grants we've received have been very helpful. We estimate a need of \$5 to \$7 million to complete our residency facility. I think smaller hospitals would struggle with this burden.

Chairman Smith – Missouri struggles in recruiting doctors. We also lead the nation in exporting physicians. What barriers in the Medicare program perpetuate this problem?

Dr. Mohr – This is a legacy of the current CMS GME funding structure, which was frozen in 1997 with caps. It made it difficult to build new programs. We need to train people in the areas where we want them to stay. Some attempts have been made to fill in these gaps such as cap reset or cap redistribution (Sec. 131, 126).

Chairman Smith – Americans in rural communities often must travel farther and work harder to receive care. The average lifespan of rural residents is much less than urban. Why do residents tend to stay in areas where they train?

Dr. Hawes – Physicians most often practice within 100 miles of their residency. During training, they become embedded in their communities and establish roots within the local healthcare infrastructure. We need to think about the places we're locating residencies and the access in these communities.

Rep. Mike Kelly (R-PA) – The rural provider shortage is similar to the rural car dealership shortage, with concerns over where money is spent and how much is on the hook for taxpayers. Our bill, the Improving Seniors' Timely Access to Care Act, can't move forward in this committee, which is a problem.

Rep. Greg Murphy (R-NC) – Has the CDC recommended against the measles vaccine?

Dr. Racine – No.

Rep. Murphy – Have you ever heard of a vaccine injury? It is not unreasonable to have reluctance to jumping in to new vaccines. Is it okay for the scientific community to question themselves? We saw examples of this in the peanut allergy issue, which relied on false data.

Rep. Judy Chu (D-CA) – 400 rural hospitals are at risk of closure after passage of the Big Ugly Bill, which also caps graduate education borrowing. Are these policies moving us closer to or further away from solving the physician shortage?

Dr. Racine – Policies that make it more difficult to afford medical school or relocate has a detrimental effect.

Rep. Chu - State abortion bans have wrecked the OBGYN workforce in this country. We've even seen pregnant women airlifted across state lines just to save their lives. How are these bans driving OBGYNs out of affected states and increasing risks for women?

Dr. Racine – I think this would be a great question for the College of Obstetricians and Gynecologists, but many newborns are seen by OBGYNs. A lot of the uncertainty around vaccines is having effects in

newborn nurseries. Many new parents are hesitant to provide necessary treatments to their newborns.

Rep. Murphy – We’ve had a population shift away from rural areas. We also need manufacturing back in our rural areas to drive new people. We added 1,200 GME slots three years ago, but the issue is misallocation and medical school graduates who don’t practice medicine. This is incumbent on those who control medical education. Despite congressional intent, these new slots didn’t reach rural areas. How do we change this?

Dr. Hawes – Sec. 126 that you’re referring to allows rural facilities to increase their spots if they want to. The prioritization of the slot distribution disincentives some rural hospitals from applying. But some programs were also helped.

Rep. Murphy – Is there reluctance from medical school executives to give up residency spots and push caregivers to rural areas?

Dr. Mohr – I can’t speak to other executives, but most folks don’t want to give up what they have. How do you pull industry into an area that doesn’t have the care to support it, how do you get caregivers to come to an area without industry? There has to be additional incentives.

Rep. Kevin Hern (R-OK) – Oklahoma’s rural physician shortage is significant. I frequently hear about burnout and administrative burdens. We have to mitigate these burdens, including through the use of technology. How are residency training programs keeping pace with changes in technology?

Dr. Mohr – Are we keeping up? We’re trying, but I’d say it’s moving too fast. We’ve created a medical AI institute which helps us with research and utilizing med technology. This could be the great equalizer for rural areas.

Rep. Hern – A new VA hospital will open in my district this year. Medical residents will complete training rotations in this hospital. Why is it important for residents to receive training in different settings of care?

Dr. Hawes – How and where you train impacts how and where you practice.

Rep. Al Horsford (D-NV) – All 17 counties in Nevada have some form of health care shortage. We used pandemic funding to implement a nurse apprenticeship program, which has greatly reduced shortages. But the new Rural Health Transformation Program (RHTP) will not be effective in the face of a trillion dollar funding cut. Can you explain why the RHTP will not deliver on its promises?

Dr. Racine – I think the program can make important inroads for certain types of care. What it will not do is replace the funding to care for individuals’ children. We need to restore cuts that have been made.

Rep. Carol Miller (R-WV) – Rural health care is incredibly important to my state. I’m also proud to introduce the Rural Residency Planning and Development Act, which would help rural hospitals with covering the upfront costs of new residency programs. What additional policy changes are needed to ensure rural communities can sustain residency programs?

Dr. Hawes – We’re looking to help you and can provide information and data on what works. We’ve seen providers use telemedicine, tele-precepting, and joint partnerships to provide care to rural patients.

Rep. Miller – We have to reduce artificial barriers to osteopathic medical education. What role do Doctors of Osteopathic Medicine play in reducing provider shortages?

Dr. Mohr – Osteopathic physicians are essential to meeting rural and underserved program needs. Yet many residency program directors say they never or rarely interview DOs. We need to have more transparency when it comes to acceptance, such as reporting of DO and MD applicants.

Rep. Brian Fitzpatrick (R-PA) – Approximately 45% of physicians reported burnout in 2023, which has partially driven shortages. I introduced the bipartisan Resident Physician Shortage Reduction Act which would add 14,000 residency slots over 7 years, prioritizing rural and underserved areas. How would this bill impact your program?

Dr. Mohr – The number one bottleneck for us is startup costs. There is less clarity into sustainable operational costs once started. This uncertainty is key for smaller hospitals and clinics, but more clarity and certainty around funding sources would be helpful.

Rep. Fitzpatrick – Many residencies are required to have telehealth capabilities. Can you address the role telehealth plays in your program?

Dr. Hawes – Telemedicine and tele-mentoring are very important for psychiatry programs.

Rep. Linda Sanchez (D-CA) – How are the Republican Medicaid cuts going to impact patients in medically underserved areas?

Dr. Racine – The function Medicaid serves is unappreciated. It is the fundamental base of all pediatric care in this country. Cuts don’t just affect children covered by the program; it will impact the ability of hospitals to provide care to all children. Children who are exposed to Medicaid in their youth have been shown to lead wealthier and healthier lives.

Rep. Sanchez – International medical graduates account for 25% of physicians in the U.S. President Trump proposed a 100,000 fee for H1B Visas. Can a rural hospital fund the cost for these?

Dr. Hawes – I can’t speak to that.

Dr. Shenefield – We haven’t had to experience that. It is obviously a different amount fiscally.

Dr. Racine – It creates an imbalance between supply and demand. Policies that impact the supply of visas will affect how we treat children in this country.

Rep. Blake Moore (R-UT) – Can you describe the different forms that rural training can take?

Dr. Hawes – We see that unique programs are designed around community need. We’ve seen prenatal programs open in areas where infant mortality is higher.

Rep. Moore – Can you describe how lifestyle medicine meets patients where they are?

Dr. Trilk – It's a way we can serve patients' needs and have providers in rural areas. We can also use community organizations in these areas to connect patients to care.

Rep. Moore – Utah became the first state to allow on AI health platform that can re-prescribe medications.

Dr. Mohr – This is a rapidly evolving field, like e-prescribing was a few decades ago. There are many opportunities to reduce administrative burden, but we know that the human element is still crucial.

Rep. Greg Steube (R-FL) – This hearing should be about accountability. Our priority should be training and retaining American providers. Do you agree that any physician visa exemption should be narrow and targeted? Should federal workforce policy be focused on training U.S. citizens? Should Congress require data reporting on the number of residency spots held by noncitizens? If Congress tightened H1B, what would rural hospitals need to ensure continuity of care?

Mr. Shenefield – It's not an easy policy fix, it would take time to train and certify American medical practitioners.

Dr. Hawes – There needs to be transparency in where slots are distributed, and where the need is.

Rep. Danny Davis (D-IL) – What steps should Congress consider to shift workforce training dollars toward community-based and rural settings?

Dr. Hawes – Those training in community health centers are more likely to remain in the community. We need to expand more opportunity for community health centers to participate in training programs.

Rep. Davis (IL) – How can we ensure Medicare invests more into training primary care providers and dentists?

Dr. Hawes – There are many ways that we're partnering with Medicare and community health centers.

Rep. Aaron Bean (R-FL) – We've based our current Graduate Medical Education slots on 1990 statistics. What if we reshuffled GME slots every ten years with the census?

Dr. Mohr – Yes, there is a benefit to this. But we also have a huge need and can't continue with the caps in place currently.

Dr. Hawes – This takes years of infrastructure, but I'd want to explore the unintended consequences.

Mr. Shenefield – We'd also want to consider the unintended consequences. It's better than keeping something in place for 30 years without changing.

Rep. Bean – How would an emphasis on nutrition, diet, and exercise save Medicare and Medicaid money?

Dr. Trilk – These community programs have been very effective in helping to save money. They also empower patients to manage their own care. Lifestyle medicine is team-based, which can really help in rural areas.

Rep. Terri Sewell (D-AL) – My district has high rates of chronic illness and “baby deserts” as rural hospitals and clinics close. Can you talk more about the benefit of having more family medicine practitioners in rural areas and how it expands access?

Dr. Hawes – The reopening of a labor and delivery ward in your state was due to a new family residency program. This also helped to lower infant mortality in the area.

Rep. Don Beyer (D-VA) – We’ve spent a long time discussing provider shortages. Does it make sense for the president to send a U.S. hospital ship to Greenland right now?

Dr. Racine – I don’t think I can answer that.

Rep. Beyer – Would you like more time to respond to Dr. Murphy’s questions on vaccines?

Dr. Racine – Dr. Murphy and I seem to disagree on things, but vaccines are safe and effective.

Rep. Beyer – Is there opportunity to move to a European educational system to produce younger doctors and reduce the shortage?

Dr. Racine – I think there’s opportunity there.

*Hearing recording:*

- <https://waysandmeans.house.gov/event/health-subcommittee-hearing-on-advancing-the-next-generation-of-americas-health-care-workforce/>