

February 24, 2026

The Honorable Jason Smith
Chairman
House Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

The Honorable Richard Neal
Ranking Member
House Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

The Honorable Vern Buchanan
Chairman
Subcommittee on Health
U.S. House of Representatives
Washington, DC 20515

The Honorable Lloyd Doggett
Ranking Member
Subcommittee on Health
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Smith, Ranking Member Neal, Chairman Buchanan, and Ranking Member Doggett:

I write to you today regarding the upcoming hearing entitled, “Advancing the Next Generation of America’s Health Care Workforce.” Thank you for your leadership on this essential topic, and hope that this could begin the dialogue on reorienting workforce development away from hospital-based programs that produce more specialists and towards community-based settings that would meaningfully improve access to primary care.

For the past 55 years, the National Association of Community Health Centers (NACHC) has been the leading national, nonpartisan organization dedicated to supporting Community Health Centers (CHCs) (also known as Federally Qualified Health Centers) as the Employer, Provider, and Partner of Choice in all communities. CHCs are the foundation of the primary care system in the United States, with their committed 326,000-strong workforce and the 52 million patients they serve.

For 60 years, CHCs have provided high-quality, affordable, comprehensive care – including primary, preventive, dental, and behavioral health and pharmacy, vision, and other essential services at over 17,000 locations across rural, tribal, frontier, island, and urban communities. With their broad reach, CHCs now serve 1 in 3 rural residents and 1 in 2 living in poverty. Additionally, there is strong evidence, as noted by the Congressional Budget Office, that CHCs improve people’s lives while saving Medicaid and Medicare billions of dollars through reducing preventable emergency room visits, hospital admissions, and invasive procedures.ⁱ Research also shows that every dollar invested in primary care yields a 13-to-1 return in overall health system savings.ⁱⁱ

However, more than 100 million Americans still lack adequate access to primary care, a problem partly driven by significant workforce shortages. The Health Resources and Services Administration (HRSA) estimates that over the next 12 years, there will be a shortage of more than 70,000 primary care physicians, nearly 20,000 dentists, and about 44,000 psychiatrists.ⁱⁱⁱ These shortages will be especially significant in non-metro areas, and the Committee should consider how investments in community-based interdisciplinary training programs – such as those at CHCs

– could effectively mitigate those shortages and increase access to low-cost, high-quality primary care, dental, and behavioral health.

The Triple Double Campaign: An Opportunity to Improve Outcomes and Reduce Costs

Primary care is the only part of the health system where an increased supply produces better population health^{iv} outcomes for all, increases life expectancy, and lowers long-term spending. Despite comprising more than half of all care visits, primary care accounts for only 5-6% of total health care spending in the U.S.^v This chronic underinvestment has created a perfect storm: a declining provider workforce,^{vi} fewer patients with a usual source of care,^{vii} higher rates of chronic illness and mortality,^{viii} and overall rising costs.^{ix} Without bold action, millions of Americans will lose access to the preventive and comprehensive care they need.

In response, NACHC has partnered with the American Academy of Family Physicians (AAFP) to launch the “Triple Double” campaign. In basketball, a triple double – achieving double digits in three of five categories (points, rebounds, assists, blocks, steals) – is rare, impressive, and game-changing. Teams with triple-double performances are far more likely to win the game. A health care system that achieves the primary care Triple Double will achieve better access to care, improved health outcomes at lower costs, and support a thriving primary care workforce.

The Triple Double Campaign pursues three interconnected goals:

- Double the investment in primary care from 5% to 10% of total U.S. health care spending, — not just the level, but also the form and flow of funding.
- Double primary care’s reach, beginning with CHCs, expanding annual patients served from about 10% of all Americans to 20%.
- Double the number of clinicians practicing in primary care from 20% to 40% of the health care workforce. To achieve this last goal, we must prioritize community-based training in CHCs, like the successful Teaching Health Center Graduate Medical Education (THCGME) program.

The Promise of CHC-based Training Programs

CHCs believe it is essential to train primary care providers in communities where patients live and work. Currently, the bulk of spending on training the health care workforce fails to address the needs of rural communities and underserved areas. Just 2% of all residency training occurs in rural areas,^x and only 3.5% in safety-net clinics.^{xi} Instead, more than 75% of primary care training is centered in and around hospitals, even though these clinicians ought to practice in outpatient settings.^{xii} Shifting investment in physician training toward CHCs presents a promising solution for improving access to primary care in rural and underserved communities.

HRSA’s THCGME program is supporting the training of 1,287 primary care physicians, dentists, and psychiatrists in CHCs and other community-based outpatient settings. In academic year 2024-2025, THCGME-supported clinicians, 99% of whom trained in rural and underserved areas, provided more than 1.5 million hours of patient care nationwide.^{xiii} HRSA estimates that THCGME has already reduced the nationwide shortage of primary care providers by approximately 2.1%, the family medicine physician shortage by 4.6%, and the pediatrician shortage by 1.6% since the program’s inception in 2011.^{xiv} Compared to traditional residencies, THCGME graduates are more likely to practice in a rural location and provide medically assisted treatment or behavioral health

care.^{xv} Teaching Health Centers attract residents from rural and/or other disadvantaged backgrounds.^{xvi}

THCGME graduates are also more likely to work in safety net clinics than residents who did not train in those centers.^{xvii} Residents trained in THCGME programs are better prepared to offer team-based care that is more cost-effective and more responsive to the needs of rural communities. This model generated \$1.8 billion in savings to Medicare and Medicaid between 2019 and 2023.^{xviii}

However, the level and unpredictability of funding for THCGME have constituted significant impediments to the expansion of this training model. For example, although the Consolidated Appropriations Act, 2026, establishes four years of funding with increases to support program growth, it follows a series of short-term extensions that created prolonged uncertainty. This stands in marked contrast to the Medicare GME financing structure, which is not subject to annual appropriations and therefore provides substantially greater stability. If Congress were to allocate even 5% of Medicare GME funding to THCGME, the resulting investment—approximately \$1 billion per year—would enable meaningful expansion to additional CHCs and strengthen the training pipeline for primary care clinicians serving rural and underserved communities.

A Different Approach to Primary Care Workforce Training

To reiterate, while Congress' recent increased investment in THCGME of \$225 million in fiscal year 2026, with \$25 million annual increases through 2029 is deeply appreciated, this amount pales in comparison to the \$22 billion Medicare spends on hospital-based GME.^{xix}

Congress's most recent attempt in 2021 at directing the Centers for Medicare and Medicaid Services (CMS) to allocate 1,000 new Medicare-funded training slots over five years to produce primary care providers in rural areas seems not to have gone as intended, with the Government Accountability Office (GAO) finding that the majority of positions went to specialist training at large urban hospitals.^{xx}

As the Committee considers reforms to advance the next generation of our America's health care workforce, I strongly urge you to consider the proven success of the community-based THCGME model and apply its core principles to Medicare-funded GME by:

- Directing CMS to require all Medicare-funded primary care training programs to include at least a substantial portion of outpatient clinical rotation time in CHCs;
- Calling upon accreditation bodies such as ACGME to specify that all primary care training programs should include a CHC clinician or community board member in their faculty or leadership group;
- Implementing guardrails to ensure that future CMS allocations of new Medicare-funded training slots produce primary care physicians who practice in rural areas and underserved communities;
- Removing statutory barriers that prevent CHCs from directly receiving GME payments through the Medicare FQHC Prospective Payment System (i.e., Medicare should consider CHCs as "primary care teaching sites") and that limit reimbursement when faculty remotely supervise residents;

- Instructing CMS and HRSA to better coordinate cost-reporting and claiming of resident time between hospitals and CHCs to ensure neither loses access to federal GME funds due to misplaced concerns about duplicate funding support;
- Asking CMS to promulgate regulations that permit Indirect Medical Education payments to CHCs to supplement any Direct Medical Education funds they may receive from HRSA;
- Investing in primary care workforce development technical assistance center(s) operated by or in partnership with a national organization that has a successful track record of supporting CHC operations for decades;
- Updating to formulas or algorithms that CMS uses to reallocate GME slots when an existing residency program closes to consider prioritizing programs that include CHC-based training;

Additionally, as CMS continues to support states' implementation of the Rural Health Transformation Program, it may be prudent to incentivize increased investment in CHC-based primary care workforce training in every state going forward.

I appreciate your consideration of the suggestions in this letter and look forward to working with the Committee to advance these ideas that will help build the next generation of the health care workforce. If you have any questions, please contact NACHC's Chief Policy Officer Joe Dunn at jdunn@nachc.org.

Sincerely,



Kyu Rhee, MD, MPP
President & Chief Executive Officer

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ⁱⁱⁱ Health Resources and Services Administration. National Center for Health Workforce Analysis. <https://bhwh.hrsa.gov/data-research/projecting-health-workforce-supply-demand>

^{iv} National Academies of Sciences, Engineering, and Medicine. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press, 2021. <https://doi.org/10.17226/25983>

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^{vii} Milbank Memorial Fund. (2025). Primary Care Scorecard Data Dashboard

^{viii} Basu S, Berkowitz SA, Phillips RL, Bitton A, Landon BE, Phillips RS. Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015. *JAMA Intern Med*. 2019;179(4):506-514. doi:10.1001/jamainternmed.2018.7624

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^x United States Government Accountability Office. Physician Workforce: HHS Needs Better Information to Comprehensively Evaluate Graduate Medical Education Funding. June 2021. <https://www.gao.gov/assets/700/690581.pdf>

^{xi} United States Government Accountability Office. Graduate Medical Education: Programs and Residents Increased during Transition to Single Accreditor; Distribution Largely Unchanged. April 2021. <https://www.gao.gov/assets/gao-21-329.pdf>

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^{xiii} Health Resources and Services Administration. THCGME Brief Academic Year 2024-25. <https://bhwh.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/thcgme-brief-24-25.pdf>

^{xiv} National Center for Health Workforce Analysis. Health Resources and Services Administration. (2024). *Teaching Health Center Graduate Medical Education Program Evaluation - Academic Years 2018-2023*. <https://bhwh.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/thcgme-eval-nchwa.pdf>

^{xv} Davis, et al. "Evaluating the Teaching Health Center Graduate Medical Education Model at 10 Years: Practice-Based Outcomes and Opportunities," *Journal of Graduate Medical Education* (2022) 14(5):599-605.

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^{xx} Information on Initial Distributions of New Medicare-Funded Physician Residency Positions (GAO-26-107686). Government Accountability Office. 2025.