

REPORT 8 OF THE COUNCIL ON MEDICAL SERVICE (A-26)
Rural Health Transformation Program Update & Workforce Challenges

EXECUTIVE SUMMARY

As a follow-up to [CMS Report 3-I-25](#), Payment Models to Sustain Rural Hospitals, the Council initiated this report to provide an update on the Rural Health Transformation (RHT) program and discuss workforce challenges faced by physicians in rural settings.

In an attempt to address funding concerns in rural settings resulting from the disproportional impact of cuts to Medicare, Medicaid, and the Affordable Care Act in H.R. 1, a one-time \$50 billion RHT program was created. Three-quarters of funding will be distributed across five years, based on state applications, Centers for Medicare & Medicaid Services (CMS)-evaluated state need, and CMS-scoring of state initiatives and policies. The other one-quarter of funding will be distributed based on state policy and application alignment with the administration's stated goals and agenda. While the RHT program is a significant investment in rural health, it remains to be seen if the program is able to not only make up for deficits but support improvements for rural Americans. In addition to reviewing information on the RHT program, the Council reviewed information related to workforce challenges that are faced by rural physicians. Rural communities face significant challenges in both attracting and retaining physicians. Issues such as a lack of infrastructure, complicated certification/training opportunities, and physician burnout significantly increase the challenges faced in rural communities. Further, international medical graduates and rural-born or rural-trained medical students have been shown to be more likely to practice in rural settings, and thus programs to support and incentivize these physicians towards rural settings could bolster the rural physician workforce.

Based on its review of the RHT program and rural workforce issues, the Council recommends the adoption of four new policies. First, policy to closely monitor and educate physicians and legislators regarding the RHT program and similar initiatives. Second, policy to support the development and funding of programs designed to both implement and expand telehealth in rural settings. Third, policy to support efforts to ensure that physicians practicing in rural settings have access to continuing medical education and professional development requirements. Fourth, policy to support the expansion of programs designed to support or define physician shortage areas to include specialties necessary for the functioning of a rural medical practice or hospital. Finally, the Council recommends the reaffirmations of Policy H-465.994, which outlines efforts to support rural health solutions, Policy D-200.980, which details strategies to bolster the physician workforce in underserved areas, and Policy H-465.988, which focuses on supporting the physician workforce through education and practice-based solutions.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 8-A-26

Subject: Rural Health Transformation Program Update & Workforce Challenges

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee A

1 As a follow-up to [CMS Report 3-I-25](#), Payment Models to Sustain Rural Hospitals, the Council on
2 Medical Service initiated this report which provides an update on the federal Rural Health
3 Transformation (RHT) program and discusses workforce recruitment and retention in rural settings.
4 Further, this report reviews relevant American Medical Association (AMA) policy and offers
5 recommendations to support the physician workforce in rural settings.

6
7 Given the complexity of rural health, the Council will continue to monitor and, as appropriate,
8 initiate future reports on aspects of rural health which may include topics such as scope of practice,
9 federal designation, Medicare Advantage, alternative payment models, immigration pathways for
10 physicians intending to practice in rural settings, and/or educational pathways to bolster the rural
11 physician workforce.

12 BACKGROUND

13
14 While the vast majority of land in the United States (U.S.) is considered rural, only 20 percent of
15 Americans live in these areas.¹ Vermont has the highest percentage of rural residents, with over 66
16 percent living in rural areas while California has the lowest percentage of rural residents, with just
17 under six percent of the state residing in rural areas.^{1,2} Rural communities tend to have older
18 residents with higher rates of chronic illness, lower rates of adequate health insurance coverage,
19 and less access to health care. Specifically, rural Americans have higher rates of heart disease,
20 cancer, stroke, unintentional injury, suicide, maternal and infant mortality, and drug overdose
21 mortality than non-rural Americans.^{1,2} These issues are exacerbated by the fact that 80 percent of
22 rural Americans live in communities that are considered medically underserved.² Rural
23 communities face a number of demographic, environmental, economic, and social factors that often
24 result in residents facing significant barriers to receiving health care.^{1,2} For example, rural
25 physicians/practices often do not receive adequate payment to sustain care, struggle to maintain or
26 qualify for governmental support, lack the infrastructure to support potential solutions, and struggle
27 to recruit and retain an adequate health care workforce.^{1,2} Additional details on the state of rural
28 health can be found in [CMS Report 9-A-21](#), Addressing Payment and Delivery in Rural Hospitals,
29 [CMS Report 9-A-23](#), Federally Qualified Health Centers and Rural Health, and [CMS Report 3-I-](#)
30 [25](#), Payment Models to Sustain Rural Hospitals.

31
32
33 In rural settings, hospitals and medical practices face a unique challenge in that payments often do
34 not cover the actual cost of care. Some federal programs do bolster Medicare payment rates to
35 offset a portion of the discrepancy. However, these programs are primarily focused on hospitals
36 that meet specific criteria, meaning that physician practices and non-designated hospitals are not
37 eligible to receive these additional funds.³ Moreover, even for those hospitals that are able to
38 receive special designation, the increased Medicare payment rates are often not enough to cover the
39 deficits from other payers.³ Medicare Advantage (MA) plans have proven to be particularly

1 problematic for those practicing in rural settings as protections found in traditional Medicare do not
 2 carry over to MA plans and issues with payment can be even worse than with other payers.^{4,5}
 3 Importantly, Medicaid also makes up a relatively significant portion of the rural payer mix, with 41
 4 states adopting some kind of Medicaid expansion program, decreasing the number of uninsured
 5 rural patients. To assist in mitigating the cost discrepancies, Medicaid provides supplemental
 6 payments to match Medicare payment rates.⁶ However, this is not available in all practice settings
 7 nor enough to cover all deficits.⁶ Additionally, these deficits are often exacerbated by uninsured or
 8 underinsured patients. More detailed information on rural payment and payer mix can be found in
 9 [CMS Report 6-I-23](#) and [CMS Report 3-I-25](#).

10
 11 As previously mentioned, rural Americans are more likely than their urban or suburban
 12 counterparts to lack adequate health insurance coverage, meaning that rural providers are often
 13 faced with a greater amount of uncompensated care.⁷ While this has been mitigated in many states
 14 that have chosen to implement Medicaid expansion, which with the inception of the Affordable
 15 Care Act (ACA) and after legal battles, allowed states to voluntarily expand the populations that
 16 qualify for Medicaid access. In states that chose to expand, the rates of uninsured individuals
 17 dropped sharply, with some research demonstrating nearly 15 percent lower rates of uninsured
 18 residents when compared to states that did not choose to expand Medicaid.⁷ The impact on rural
 19 residents was even stronger as nearly one quarter of rural adults and almost half of rural children
 20 are enrolled in their state Medicaid program.⁷ However, the recently passed [H.R. 1](#) (or the “One
 21 Big Beautiful Bill Act”) is anticipated to have a negative impact on Medicaid coverage eligibility,
 22 including expansion access, as well as other types of insurance and payment rates.^{7,8}

23
 24 Experts anticipate that over 10 million Americans will lose health insurance coverage as a result of
 25 the changes in H.R. 1 and that, across payer type, beneficiaries will face significant increases in
 26 premium costs.^{8,9} It is projected that in a majority of states, this premium increase will be more
 27 significant for rural Americans. Specifically, analyses have shown that on top of the 18 percent
 28 increase for all private health plans, rural Americans will face a 107 percent premium increase
 29 compared to the 89 percent premium increase for urban residents.^{8,9} Additionally, rural residents
 30 who utilize the ACA Health Insurance Marketplace Exchange (“Marketplace”) to secure insurance
 31 coverage are anticipated to experience premium increases that are 28 percent higher than urban
 32 residents, primarily driven by the lack of extension of previously available tax credits designed to
 33 help make coverage affordable.^{8,9} This is problematic as rural communities rely more heavily on
 34 affordable Marketplace plans to obtain health insurance.^{8,9} Further, due to additional challenges
 35 around rural employment and coverage determination logistics in rural settings, it is anticipated
 36 that the Medicaid work requirements outlined in H.R. 1 will disproportionately impact rural
 37 communities.^{9,10} According to the Centers for Medicare & Medicaid Services (CMS), there have
 38 not been actual cuts to Medicaid or other public coverage options, but rather that these
 39 expenditures were “slowed” and that any reduction in funding is focused on reductions of waste
 40 and/or fraud. However, rural health leaders and researchers have explained that these policy
 41 changes have already resulted in funding reductions negatively impacting rural health facilities and
 42 will likely continue to disproportionately impact rural providers and the communities they serve.¹¹
 43 Experts, providers, and patients have voiced significant concern that these coverage losses have the
 44 potential to significantly worsen the landscape of rural health through increased financial stress on
 45 vulnerable rural hospitals and practices.

46
 47 RURAL HEALTH TRANSFORMATION (RHT) PROGRAM UPDATE

48
 49 In an attempt to address concerns around funding reductions, H.R. 1 included a one-time \$50
 50 billion program designated for rural health transformation.^{10,12} While the RHT program is clearly a
 51 significant investment in rural health, it is anticipated that it will not make up for the projected

1 losses to rural hospitals and providers as a result of policy changes due to H.R. 1. It is projected
2 that changes made to the ACA, Medicare, and Medicaid will result in rural hospitals losing \$137
3 billion over the next 10 years, meaning that even with the rural health fund, rural hospitals are
4 anticipated to lose \$87 billion over the next decade due to patients who will lose coverage through
5 Medicare, Medicaid, and/or Marketplace plan changes.^{10,12,13} The deficit created by the cuts
6 resulting from the passage of H.R. 1, and other policy decisions such as the expiration of the
7 enhanced ACA tax credits, is likely to cause financial problems for rural hospitals and other health
8 care providers beyond what is potentially solved by the dollars dispersed through the RHT
9 program.^{10,13}

10
11 The RHT program has been launched, and all 50 states have applications that have been
12 preliminarily approved by CMS. Three-quarters of the funds in this program are designated to be
13 divided between all states, with half distributed equally across states that have approved
14 applications and a quarter allocated based on CMS-evaluated state need.^{10,12,13} The final one quarter
15 of funding, \$12.5 billion, will be distributed based on CMS scoring of state policy, state initiatives,
16 and other factors yet to be released.^{13,14} CMS has indicated that \$8 billion of these funds,
17 distributed in the first few years of the program, will be based on a qualitative review of the
18 proposed initiatives in the RHT program applications. Thirty percent of these funds will be
19 distributed later based on state policies, or progress towards state policies, that align with the
20 “Make America Healthy Again” (MAHA) agenda.^{13,14} The final \$750 million will be distributed
21 based on other factors that have not yet been announced but may include the quality of Medicaid
22 data reporting or dual eligible integrated care plans.^{12,13,14,15} While the actual formula has not been
23 released, the notice of funding for this program outlines discretion for CMS to award states higher
24 levels of funding if policies align with the federal administration’s priorities. As a result, some
25 states are pledging to implement policies that align with MAHA stated goals in an attempt to
26 garner a greater amount of the discretionary portion of the RHT program funds. Of concern, a
27 number of RHT program applications include specific reference for movement toward licensure
28 expansion for non-physician practitioners.¹⁴ For example, some applications expand the ability of
29 pharmacists to test and treat and/or allow for non-physician advanced practice providers to practice
30 independently. While it is likely that these programs could have some positive impacts on the
31 communities they serve, it remains important that the provision of medical services occur within
32 the purview of a physician-led team.

33
34 At the end of 2025, CMS announced initial RHT program awards for Fiscal Year 2026 (FY26).
35 State awards ranged from \$154,249,106 for Connecticut to \$281,319,361 for Texas. A full list of
36 state funding awards for FY26 can be found in Appendix A. The assessment of more subjective
37 elements of applications, such as state alignment with the “MAHA agenda” or the “quality” of
38 reporting, has not been made public. As a result, the full picture of actual funding for states is yet to
39 be seen. Should awards be evenly distributed across states, each would receive \$750 million over
40 five years. However, as was evidenced by the FY26 funding announcement, experts anticipate
41 there will be significant variance in awards.^{13,14} Researchers project that actual awards could range
42 from \$550 million in Rhode Island to over \$1 billion in Texas. This discrepancy could be further
43 exacerbated by the discretionary \$12.5 billion portion of the fund that will be determined by CMS
44 assessment of state policy and legislation.^{12,13,14,15} It is anticipated that Texas, California, New
45 Mexico, Montana, and Alaska will receive the largest portions of the needs-based funding. Since
46 rural population numbers are not fully taken into account, payment per rural resident is anticipated
47 to vary greatly across states.^{12,13,14,16} For example, although it is anticipated to receive a high
48 proportion of funding, Texas is projected to receive only \$240 per rural resident while Rhode
49 Island is projected to receive over \$22,000 per rural resident -- both of which are significant
50 deviations from the nationwide projected average of \$590 per rural resident.^{13,14,15}

1 In addition to potential significant funding discrepancies between states, the ambiguity of the fund
 2 allocation may mean that rural health care providers may not receive the full allocated
 3 funds.^{10,12,13,14} For example, states are given the ability to direct funding towards urban and
 4 suburban settings with the approval of CMS.^{10,12,13,14} Further, the administration has outlined
 5 intentions to “claw back” funding dispersed via the RHT program should states not successfully
 6 implement the intended program(s) in the allotted timeline. The program grants state a limited
 7 timeline, at most five years, to implement the initiatives outlined in applications. States and
 8 national rural health advocacy organizations have voiced significant concerns that this timeline is
 9 not reasonable and, as a result, funding that is given to many states may end up being taken back by
 10 the federal government.¹⁷ Not only do states have a limited timeline to implement these policies,
 11 the program’s notice of funding outlined a potential risk to state funding beyond the first year if
 12 states do not demonstrate outcomes deemed sufficient by CMS. For many states this means that
 13 new policies will need to be implemented that align with stated MAHA/administration goals and
 14 should these policies not be implemented, funding beyond the first year may be limited or reduced.
 15 Further, the funding from this program is limited to the next five years, but the reductions in
 16 Medicare, Medicaid, and ACA funding or coverage are ongoing. As a result, after the RHT
 17 program is finished, the impacts of the cuts are likely to remain and rural health providers/facilities
 18 will be without additional support to mitigate the cuts.¹⁸ While the RHT program will likely help
 19 mitigate some of the funding reductions faced in rural settings, the level of compensation may be
 20 inadequate and the potential for politicization of available funds may result in many rural residents
 21 losing access to crucial health care.

22

23 **RURAL WORKFORCE CHALLENGES**

24

25 As shrinking funding and payment has stretched hospitals and health care providers across the
 26 country, the United States is facing a growing physician shortage that it is exacerbated in rural
 27 communities. Specifically, research suggests that in the next decade rural communities may face a
 28 23 percent decline in physicians compared to just nine percent in non-rural settings.¹⁹ Further,
 29 studies show that rural communities have, on average, 236 fewer physicians per 100,000 people
 30 when compared to urban areas.²⁰ These shortages are not due to any single factor, but rather a
 31 combination of hospital/practice closures, lack of new physicians, practice challenges, and issues
 32 with infrastructure. Further, despite programs designed to support rural hospitals, many are
 33 struggling to stay open as challenges continue to grow.^{22,23} In recent years, the number of rural
 34 hospitals operating at a deficit has grown nearly seven percent.²² Today, half of all rural hospitals
 35 are operating at a deficit. In some states, such as Kansas and Wyoming, the problem is even worse
 36 with over 80 percent of rural hospitals operating in a deficit.^{22,23} Even among rural hospitals that
 37 have chosen to affiliate with larger health systems, 42 percent are operating at a deficit.^{22,23,24} More
 38 than 140 rural hospitals have closed since 2010 and a third of the remaining rural hospitals are
 39 financially vulnerable, placing access to emergency and inpatient care at risk for millions of rural
 40 residents. This is leading to many rural hospitals being forced to close or reduce services. For
 41 example, between 2011 and 2021, nearly 25 percent of all rural obstetric and gynecologic units
 42 were closed and access to chemotherapy decreased at a similar rate.^{25,26} While not exclusively
 43 responsible, these hospital closures have increased the rural physician shortage.

44

45 *Infrastructure*

46

47 Beyond hospital closures, the chronic lack of investment in rural infrastructure has resulted in
 48 many rural communities lacking basic infrastructure necessary to support community growth or
 49 maintain an adequate physician workforce. These communities often lack resources such as
 50 updated roads, utilities, broadband access, schools, and sanitation necessary to attract and retain
 51 businesses and bolster economies.²⁷ As infrastructure becomes less maintained, businesses close or

1 reduce employee hours, and as a result, communities shrink in size. The issue is often cyclical; a
 2 community economy is not enough to sustain a physician and/or hospital, but when a physician or
 3 hospital leaves a community, it hurts the economy as well.^{28,29} This remains true for physician
 4 practices as evidence shows that each physician supports, on average, 17.1 jobs and generates
 5 approximately \$3.2 million in economic output across their full career.²⁸ Across physician offices
 6 and hospitals, residents of rural census tracts, rural residents live three to four times further away
 7 from hospitals than those in urban or suburban areas.³⁰ When patients do travel these greater
 8 distances, they often encounter roads that are difficult to pass due to poor upkeep, difficult terrain,
 9 and/or dangerous weather. Additionally, poor system infrastructure, like faulty sanitation systems
 10 or lack of clean water, can lead to poorer health outcomes for rural residents.²⁷ For example, for
 11 some towns in Mississippi, estimates show that nearly 40 percent of children have chronic
 12 stomach problems due to parasitic infections linked to raw sewage in drinking water from failing
 13 infrastructure.³¹

14
 15 Not only do these issues of infrastructure directly impact patient health and health outcomes, but
 16 they also indirectly impact physician workforce. Communities that do not have adequate
 17 infrastructure are less likely to be attractive for new physicians and can be detrimental in retaining
 18 the existing physician workforce.^{27,32,33} Additionally, the lack of infrastructure often makes
 19 potential solutions, to mitigate the rural health crisis nearly impossible to implement. For example,
 20 telehealth has promise to bolster rural health care networks; however, nearly a quarter of rural
 21 Americans lack access to high-speed internet, compared to only 1.5 percent of urban Americans.²⁷
 22 Further, rural practices and hospitals may be less likely to be able to offer competitive pay and/or
 23 benefits exacerbating challenges to both recruit and retain workforce.^{27,31,32,34}

24
 25 *Physician Recruitment and Retention*

26
 27 Data suggest that the vast majority of medical students and trainees do not intend to practice in
 28 rural communities.³⁵ While research has demonstrated that students who are from a rural
 29 community are more likely to return to a rural setting to practice, the number of rural medical
 30 students has been declining. Estimates show that less than five percent of medical students report
 31 they are from a rural background, meaning that this cannot be the single solution to bolstering the
 32 rural physician workforce.³⁵ Along with rural-born trainees, international medical graduates
 33 (IMGs) can be an important element in the rural physician workforce. In addition to obtaining the
 34 appropriate visa to practice in the United States, these physicians must obtain an Education
 35 Commission on Foreign Medical Graduates certification, pass appropriate exams, and complete
 36 their residency in the United States. IMGs are essential to meeting the health care needs of
 37 Americans across the country, but especially in underserved and rural communities.³⁶ Research
 38 shows that IMGs make up nearly a quarter of all practicing physicians in America and represent a
 39 disproportionate amount of physicians in rural and underserved settings.³⁷

40
 41 While states vary widely in proportions of practicing IMGs, likely due to differing visa legislation
 42 and regulation, nationwide estimates continually demonstrate that IMGs are vital to ensuring that
 43 rural Americans have access to physicians.³⁸ This became a greater challenge for many hiring
 44 facilities with the implementation of a new H-1B visa fee and changes to the visa lottery process.
 45 Historically, the visa lottery process was randomized, but the Department of Homeland Security
 46 (DHS) recently implemented a weighting system based on higher skill and pay positions. Further, a
 47 \$100,000 fee is now attached to all H-1B petitions, which for many rural facilities is an
 48 insurmountable and/or unsustainable figure. A number of health care advocacy organizations,
 49 including the AMA, have urged DHS and the Trump administration to implement a fee exemption
 50 for health care professionals. In March 2026, a bipartisan bill (H.R. 7961; [H-1Bs for Physicians](#)
 51 [and the Healthcare Workforce Act](#)) was introduced and if passed would exempt physicians and

1 health care professionals from the aforementioned \$100,000 filing fee attached to new H-1B
 2 petitions. However, at the time that this report was written, this legislation has not passed Congress
 3 and no such exception has been put in place.^{38,39}

4
 5 With physician burnout rate at a high across the nation, it is no surprise that rural physicians also
 6 face burnout.³⁶ Rural physicians are frequently the only, or one of the few physicians in their area
 7 and as a result they are often asked to do more with fewer resources.^{27,40} Heavier clinical workloads
 8 and professional isolation in rural practice environments may contribute to physician burnout and
 9 can make recruitment and retention more difficult for rural communities.^{27,40} Further, physicians
 10 practicing in rural areas may find it more challenging to complete continuing professional
 11 development (CPD) requirements.⁴¹ While neither physician burnout nor the challenges around
 12 certification and CPD requirements is solely responsible for rural physician shortages, each
 13 contributes to the challenges that rural health employers have in both recruiting and retaining
 14 physicians.

15
 16 POTENTIAL SOLUTIONS

17
 18 While there is no single solution that will solve the health care problems faced by rural
 19 communities, there are some actions that could be taken to work toward improvement. One
 20 promising element toward progress is the support and expansion of telehealth services.⁴² Telehealth
 21 and associated remote patient care could be a lifesaving stopgap while the larger access issues are
 22 being addressed.^{41,42} Telehealth has been associated not only with better patient outcomes, both in
 23 health and satisfaction, but also with shorter wait times and reductions in delays of care and
 24 diagnosis/treatment.⁴⁴ Research shows that patients treated by rural hospitals utilizing telehealth are
 25 more likely to receive stroke care within the crucial “golden hour” for treatment. Additionally,
 26 physician satisfaction is higher and physicians, particularly specialists, are less likely to report
 27 burnout when their practice utilizes telehealth.^{42,44} However, for telehealth implementation to be
 28 successful in rural areas, there would need to be an increase in access to reliable high-speed
 29 broadband in rural communities.⁴³ Another challenge related to the implementation of telehealth is
 30 the cost for hospitals and practices. Estimates for initial startup costs in rural hospitals range from
 31 \$17,000 to \$50,000 with annual subscription fees over \$50,000. For many rural hospitals and
 32 practices, this is an insurmountable amount of money.⁴² While many of the applications submitted
 33 to the RHT program include an element of telehealth, it is yet to be seen if the funds distributed by
 34 the program will be sufficient to implement and/or sustain telehealth programs in these
 35 communities.¹⁴

36
 37 Experts agree that in addition to encouraging rural-born medical students to return to rural practice
 38 as physicians, it is equally important to expose non-rural-born medical students to these
 39 communities. For example, the University of Washington School of Medicine’s [Rural Underserved](#)
 40 [Opportunities Program](#) allows medical students to rotate through rural care settings in five states
 41 during their first two years of medical education. This program has shown that their students who
 42 train in rural sites are twice as likely to return to practice as physicians in rural areas.⁴⁵ Other
 43 programs, such as the [Family Medicine Rural Residency Program](#), can be found across the country
 44 and are designed to expose physicians to a variety of rural practice settings during their residency.
 45 Specifically, this program includes both inpatient and outpatient rotations at a hospital which is the
 46 only one in the county.⁴⁶ These programs, sometimes referred to as “Grow Your Own Doctor”
 47 programs, can be instrumental in ensuring that medical students and residents are more likely to
 48 return to rural medical practice for their career.

49
 50 Further, loan forgiveness programs continue to provide an incentive for physicians to practice in
 51 rural communities.^{43,47} The Health Resources and Services Administration (HRSA) offers a number

1 of funding programs designed to attract new physicians to rural areas. For example, the [State Loan](#)
 2 [Repayment Program](#) and the [National Health Service Corps](#) (NHSC) both provide loan repayment
 3 and scholarships to physicians providing primary care in provider shortage areas. The Indian
 4 Health Service (IHS) [Loan Repayment Program](#) offers similar benefits to physicians/trainees who
 5 commit to practicing in IHS settings. Further, many states allocate funds designed to expand these
 6 programs and/or provide additional incentives to physicians.⁴⁸ Research shows that loan
 7 repayment/forgiveness-based retention programs are generally successful for health care workers.⁴⁹
 8 For example, as many as two-thirds of physicians who committed to working in these communities
 9 as a result of a loan repayment or forgiveness program are still practicing in the community more
 10 than eight years later.⁵⁰ However, some research suggests that if a physician's overall loan amount
 11 is too high, the repayment or forgiveness programs may not be as attractive. In total, experts
 12 proport these types of programs as a promising aspect to mitigate the rural physician shortage, but
 13 not the single solution.⁵¹

14
 15 To facilitate the success of these programs, it also is essential that there are a sufficient number of
 16 residency slots in rural areas. Notably, the [Rural Residency Planning and Development Program](#)
 17 has introduced over 500 new residency slots in rural areas, allowing repayment programs to have
 18 the space to function and more physicians to be trained in rural settings.⁵² Beyond loan-based
 19 programs, general recruitment strategies have been shown to be successful in recruiting physicians
 20 to rural communities. For example, programs such as housing assistance, relocation support,
 21 flexible scheduling, and mentorship/peer support can be impactful in both attracting and retaining
 22 physicians. Specifically, experts posit that providing rural physicians with creative staffing
 23 solutions can not only attract physicians but support them in remaining in rural communities.⁵³
 24 Locum tenens programs, or programs that fill open positions via temporary contract, can provide a
 25 stop-gap measure to ensure that rural hospitals have the staffing necessary to remain open.⁵³

26
 27 As previously mentioned, IMGs are an essential component to reducing physician shortages.
 28 However, in order for these physicians to practice in the United States, they must be able to secure
 29 the appropriate visa and/or waivers.⁵⁴ Often this means that physicians must secure a J-1 or H-1
 30 visa and/or a Conrad 30 waiver. Research demonstrates that more IMGs practice in states with
 31 more relaxed Conrad 30 requirements, such as an expanded visa cap. This can be incredibly
 32 beneficial in reducing the physician shortage faced in rural communities as IMGs are also more
 33 likely to practice in rural settings.^{36,54} Further, studies show no evidence of U.S.-trained physicians
 34 being "crowded out" of jobs as little to no changes in the proportion of domestically trained
 35 physicians were found.³⁶ This research seems to suggest that the expansion of slots for these visa
 36 and waiver programs may allow for IMGs to help meet the health needs of rural communities.
 37 Further, it is important to not only attract physicians to rural settings, but to support those who have
 38 chosen to practice there. Specifically, to ensure that physicians are able to meet licensure and CPD
 39 requirements, programs like the [Interstate Medical Licensure Compact](#) are working to streamline
 40 licensure.^{55,56} This program ensures that physicians are able to expedite licensure requirements in
 41 order to practice in underserved areas. These kinds of programs are helpful in ensuring that
 42 physicians can also be available to practice telehealth and promote the aforementioned benefits of
 43 those programs.^{55,56}

44
 45 To further support and attract rural-practicing physicians the federal government created the Health
 46 Professional Shortage Area (HPSA) designation and assigned particular benefits. While HPSAs are
 47 not exclusive to rural settings, there is frequent overlap. HPSAs are a geographic, population,
 48 and/or facility that has a shortage of primary, dental, or mental health care providers.⁵⁷ Geographic
 49 HPSAs, most common for rural settings, are areas where the entire population is experiencing a
 50 shortage of providers. Population HPSAs are defined as a shortage of providers for a specific
 51 population in a geographic area. For example, unhoused or migrant farm workers in a set area.

1 Facility defined HPSAs include set facilities that serve a population or geographic area facing a
2 provider shortage.⁵⁷ While not an exhaustive list, Federally Qualified Health Centers, Indian Health
3 Facilities/Hospitals, and Rural Health Clinics often meet the criteria to be defined as a facility
4 HPSA. Currently, there are just under 8,500 primary care HPSA designations across type, which is
5 inclusive of over 92 million people.⁵⁸ Physicians practicing in HPSAs are able to access a number
6 of incentives, the most significant of these incentives are related to scholarships/loans,
7 immigration, and payment bonuses. Specifically, physicians are able to access NHSC scholarships
8 and loan repayment, the J-1 visa waiver program which expedites the immigration process, and,
9 assuming the physician serves Medicare beneficiaries, a quarterly Medicare bonus payment. While
10 research has not demonstrated an improvement in physician workforce across all types of HPSAs,
11 it has shown that this designation seems to make significant improvements in rural settings,
12 demonstrating more favorable patient-physician ratios.^{58,59} Specifically, after a HPSA designation
13 significant increases in primary care physicians were shown resulting in, rural HPSAs having an
14 average of 5.4 more primary care physicians than non-HPSA rural settings.⁵⁹ While primary care is
15 essential to overall health, it is also important that rural communities have access to specialty
16 physicians when the need arises. Further, for a rural hospital to remain fully functional, there must
17 be an ability to attract and retain physicians beyond primary care. The success of the HPSA
18 designation in rural primary care could indicate that an expansion to other specialties may similarly
19 bolster the rural physician workforce. While none of these solutions alone will solve the health care
20 problems faced by rural communities, the solutions mentioned above have been shown to have an
21 impact and are specific, practical, and realistically achievable.

22 23 AMA POLICY AND ADVOCACY

24
25 The AMA has an extensive body of policy related to rural health, with some policies specifically
26 focused on physician workforce. Broadly, Policies [H-465.997](#) and [H-465.978](#) outline the AMA's
27 stance on rural health disparities and efforts to work toward improvement in access and quality of
28 rural health care both independently and in conjunction with relevant state medical associations and
29 national medical specialty societies. Policy [H-465.994](#) outlines AMA efforts to plan and promote
30 improvements in rural health through private and public support. Beyond policies designed to
31 generally promote rural health improvements there is a large group of policies dedicated to
32 bolstering the rural physician workforce. Policies, [H-465.988](#), [H-200.972](#), and [H-300.983](#) outline
33 efforts centered in education to not only encourage physicians to consider rural care but also to
34 ensure they are able to continue their training once practicing in these settings. Policies [H-200.945](#),
35 [D-465.997](#), and [H-330.864](#) address the physician workforce shortage in general, but also specific
36 strategies to recruit and retain physicians in rural areas. Policies [H-465.980](#), [H-465.994](#), [H-420.946](#),
37 and [H-350.937](#) outline strategies to advocate for better access to rural health care generally and
38 with a specific focus on OB/GYN care through the implementation of networks, and focusing on
39 minorities in rural communities. Further, Policy [H-465.981](#) outlines AMA efforts to support rural
40 physician practices and to begin to address limits on HPSA benefits, supports the expansion of the
41 associated Medicare payment bonus to rural counties that meet a set poverty threshold beyond
42 formal HPSA designation.

43
44 While telehealth is mentioned in a number of the aforementioned policies related to rural health,
45 Policy [H-478.980](#) specifically outlines AMA advocacy to support access to broadband services in
46 rural communities. Policy [H-480.937](#) outlines the AMA's stance and advocacy efforts related to the
47 implementation of telehealth and related health technologies. In addition to telehealth, the AMA
48 has policy, [D-200.982](#), related to the implementation of educational programs designed to create
49 and support pathways for students who intend to practice in rural settings. The AMA has been
50 active in this area and successfully advocated for [extensions of telehealth flexibilities](#) that were
51 initially implemented during the COVID-19 pandemic.⁴³

1 To address physician workforce, Policy [H-200.949](#) details support for physician and trainee
 2 incentives to practice in underserved rural areas while Policy [H-200.954](#) outlines AMA efforts to
 3 work to alleviate the overall physician shortage. The AMA policy is clear in support of expanded
 4 residency slots. Specifically, aforementioned Policies [H-200.949](#) and [H-200.954](#) outline support within
 5 the context of the physician workforce while Policies [H-310.943](#) and [D-305.967](#) focus more
 6 specifically on the residency program structure and sustainability. Finally, Policies [H-255.965](#), [H-](#)
 7 [255.961](#), and [D-255.969](#) all outline AMA advocacy and support for IMGs and visa processes for
 8 international physicians to be able to practice in the United States. Related, the AMA has voiced
 9 [supported](#) for recently introduced legislation that would remove the increased J-1 visa fee.
 10 Importantly, the AMA also has a robust body of policy related to prevention of scope creep and the
 11 promotion of care within a physician-led team. Specifically, Policies [H-35.966](#) and [D-160.995](#) call
 12 out protection of physician licensure and medical care within a physician-led team.

13
 14

DISCUSSION

15

16 Rural Americans deserve high-quality and readily accessible health care; however, due to a
 17 complex combination of factors, including workforce challenges, rural access to care is in crisis.
 18 The RHT program was designed as an infusion of funds into rural settings but comes with a
 19 number of challenges and restrictions that may limit the positive impact of the program. Further,
 20 the dollars designated for the RHT program may not offset the projected losses that rural providers
 21 face due to cuts to Medicare, Medicaid, and the ACA. As a result, hospitals and rural physicians
 22 have voiced significant concern regarding their ability to continue to provide care for their rural
 23 patients. To address these concerns, the Council recommends the adoption of new policy that
 24 supports ongoing AMA efforts to monitor the RHT program and similar initiative to educate
 25 physicians and legislators on the associated opportunities and challenges. While the AMA has
 26 supported and developed [educational materials](#), [Council reports](#), and, [informational sessions](#) on the
 27 RHT, the adoption of this policy will enshrine these efforts and ensure their continuance.
 28 Further, the Council recommends the reaffirmation of Policy [H-465.994](#), which outlines efforts to
 29 work towards improvements in rural health. Specifically, this policy outlines efforts to improve
 30 funding, develop evidence-based action plans, and to support innovative care models.

31

32 Rural communities also face significant challenges in recruiting and retaining a physician
 33 workforce large enough to meet population needs. The cause of workforce challenges is not
 34 monolithic, as many factors including a lack of infrastructure investment and certification/training
 35 opportunities, complicate physician workforce in rural communities. Many of the solutions that
 36 could contribute to remedying this problem are also complicated by the intricate nature of the issue.
 37 For example, while telehealth has been promoted as a part of the solution to improving access to
 38 physicians in rural communities, rural communities are less likely to have access to the reliable
 39 broadband necessary for successful telehealth implementation. Additionally, rural practices and
 40 hospitals are less likely to have the necessary capital to establish or continue these programs. In
 41 order to address this, the Council recommends the adoption of new policy supporting funding for
 42 telehealth implementation and improvement in rural settings. Further, the Council notes recently
 43 reaffirmed Policy [H-478.980](#) outlines AMA advocacy for reliable broadband in rural settings to
 44 address health disparities.

45

46 Internationally trained physicians could also serve to improve rural health workforces, yet the
 47 solution faces barriers to success. Although IMG physicians have been shown to be more likely to
 48 practice in rural settings, the complicated immigration and certification process in the U.S. can
 49 introduce barriers to this solution. Another promising potential solution is educational pathways
 50 that promote rural health practice. Through medical school and residency experiences in rural
 51 communities, physicians are introduced to the benefits of practice in these settings and are more

1 likely to return. Similarly, programs that help to pay off or forgive student loans have shown to be
2 successful in attracting and retaining talent. In order to both support IMG's ability to practice in the
3 rural United States and to promote U.S.-trained physicians in rural practice, the Council
4 recommends the reaffirmation of Policy D-200.980 which outlines support for scholarship, loan
5 repayment or forgiveness programs, and the expansion of visas for IMGs. Specifically, this policy
6 supports collaborative efforts to secure funding and advocate for the retention and expansion of
7 relevant programs such as the NHSCs and the Conrad 30 visa. Further, the Council recommends
8 the reaffirmation of Policy H-465.988 which outlines educational strategies to attract and retain
9 physicians to rural settings. This policy details efforts to ensure that appropriate training slots are
10 available for medical students and residents, that education is delivered in a manner that is
11 accessible, and that funding is maintained or expanded to secure these program efforts.
12

13 In order to ensure that physicians who choose to practice in rural settings are able to continue,
14 opportunities to meet licensure and CPD requirements in rural settings must be enhanced.
15 Therefore, the Council recommends new policy designed to ensure that practicing rural physicians
16 have accessible opportunities to meet continuing education and CPD requirements. Finally, the
17 promise shown by both defining and incentivizing rural practice via the HPSA in bolstering the
18 rural primary care physician workforce could indicate an area of advocacy to expand the success to
19 physician specialties. Thus, the Council recommends the adoption of new policy that indicates
20 AMA support for the expansion of programs that define and support physician shortage areas to
21 include specialties in an effort to ensure that rural medical practices and hospitals can attract the
22 full spectrum of physicians necessary.
23

24 RECOMMENDATIONS

25

26 The Council on Medical Service recommends that the following recommendations be adopted and
27 the remainder of the report be filed:
28

- 29 1. That our American Medical Association (AMA) monitor legislative and regulatory proposals
30 related to the rural health transformation program or similar rural health initiatives to educate
31 physicians and policymakers regarding the potential opportunities and challenges associated
32 with such programs. (New HOD Policy)
33
- 34 2. That our AMA support the development of funding avenues designated to support costs
35 associated with telehealth in rural hospitals and medical practices. (New HOD Policy)
36
- 37 3. That our AMA support the development and implementation of programs that ensure
38 physicians practicing in rural settings have access to opportunities to meet continuing medical
39 education and continuing professional development requirements. (New HOD Policy)
40
- 41 4. That our AMA encourage the expansion of programs designed to define physician shortage
42 areas and support physicians working in these areas to include specialties necessary to the
43 functioning of a rural medical practice or hospital. (New HOD Policy)
44
- 45 5. That our AMA reaffirm Policy H-465.994, which details efforts to support, promote, and
46 innovate solutions to improve rural health. (Reaffirm HOD Policy)
47
- 48 6. That our AMA reaffirm Policy D-200.980, which outlines support for various strategies to
49 bolster the physician workforce in underserved areas, including rural communities. (Reaffirm
50 HOD Policy)

- 1 7. That our AMA reaffirm Policy H-465.988, which specifies strategies and efforts to improve the
- 2 physician workforce that focus on education and practice solutions. (Reaffirm HOD Policy)

Fiscal Note: Minimal

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Council on Medical Service Report 8-A-26
Rural Health Transformation Fund Update & Workforce Challenges
Policy Appendix

Improving Rural Health H-465.994

1. Our American Medical Association (AMA):
 - a. supports continued and intensified efforts to develop and implement proposals for improving rural health care and public health,
 - b. urges physicians practicing in rural areas to be actively involved in these efforts, and
 - c. advocates widely publicizing AMA's policies and proposals for improving rural health care and public health to the profession, other concerned groups, and the public.
2. Our AMA will work with other entities and organizations interested in public health to:
 - a. Encourage more research to identify the unique needs and models for delivering public health and health care services in rural communities.
 - b. Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
 - c. Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians and public health professionals in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
 - d. Advocate for adequate and sustained funding for public health staffing and programs
3. Our American Medical Association will work with relevant stakeholders to develop a national strategy to eliminate rural cancer disparities in screening, treatment, and outcomes and achieve health equity in cancer outcomes across all geographic regions.
4. Our AMA calls for increased federal and state funding to support research on rural cancer disparities and equity in care, access, and outcomes and development of interventions to address those disparities.
5. Our AMA advocates for evidence-based collaborative models for innovative telementoring/teleconsultation between health care systems, academic medical centers, and community physicians to improve access to cancer screening, diagnosis, treatment, rehabilitation, and patient services in rural areas. (Sub. Res. 72, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 433, A-19; Modified: CSAPH Rep. 2, A-22; Reaffirmed: CMS Rep. 09, A-23; Reaffirmed: Res. 724, A-23; Appended: Res. 919, I-24)

Educational Strategies for Meeting Rural Health Physician Shortage H-465.988

1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, our American Medical Association (AMA) recommends that:
 - a. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.
 - b. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.
 - c. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.

- d. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.
 - e. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.
 - f. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.
 - g. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.
 - h. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.
 - i. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.
 - j. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.
 - k. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.
 - l. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.
2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.
 3. Our AMA will:
 - a. work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and
 - b. work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.
 4. Our AMA will encourage ACGME review committees to consider adding exposure to rural medicine as appropriate, to encourage the development of rural program tracks in training programs and increase physician awareness of the conditions that pose challenges and lack of resources in rural areas.
 5. Our AMA will encourage adding educational webinars, workshops and other didactics via remote learning formats to enhance the educational needs of smaller training programs. (CME Rep. C, I-90; Reaffirmation A-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmed: CME Rep. 1, I-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 956, I-18; Appended: Res. 318, A-19; Modified: CME Rep. 3, I-21; Reaffirmation: I-22; Reaffirmed: BOT Rep. 11, A-23; Reaffirmed: Res. 215, I-24; Reaffirmed: BOT Rep. 07, I-24)

Rural Health Physician Workforce Disparities D-465.997

Our AMA will monitor the status and outcomes of the 2020 Census to assess the impact of physician supply and patient demand in rural communities. (CME Rep. 3, I-21)

Improving Rural Health H-465.994

1. Our American Medical Association:

- a. supports continued and intensified efforts to develop and implement proposals for improving rural health care and public health,
 - b. urges physicians practicing in rural areas to be actively involved in these efforts, and
 - c. advocates widely publicizing AMA's policies and proposals for improving rural health care and public health to the profession, other concerned groups, and the public.
2. Our AMA will work with other entities and organizations interested in public health to:
 - a. Encourage more research to identify the unique needs and models for delivering public health and health care services in rural communities.
 - b. Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
 - c. Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians and public health professionals in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
 - d. Advocate for adequate and sustained funding for public health staffing and programs
 3. Our American Medical Association will work with relevant stakeholders to develop a national strategy to eliminate rural cancer disparities in screening, treatment, and outcomes and achieve health equity in cancer outcomes across all geographic regions.
 4. Our AMA calls for increased federal and state funding to support research on rural cancer disparities and equity in care, access, and outcomes and development of interventions to address those disparities.
 5. Our AMA advocates for evidence-based collaborative models for innovative telementoring/teleconsultation between health care systems, academic medical centers, and community physicians to improve access to cancer screening, diagnosis, treatment, rehabilitation, and patient services in rural areas. (Sub. Res. 72, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 433, A-19; Modified: CSAPH Rep. 2, A-22; Reaffirmed: CMS Rep. 09, A-23; Reaffirmed: Res. 724, A-23; Appended: Res. 919, I-24)

Improving Healthcare of Minority Communities in Rural Areas H-350.937

1. Our AMA encourages health promotion, access to care, and disease prevention through educational efforts and publications specifically tailored to minority communities in rural areas.
2. Our AMA encourages enhanced understanding by federal, state and local governments of the unique health and health-related needs, including mental health, of minority communities in rural areas in an effort to improve their quality of life.
3. Our AMA encourages the collection of vital statistics and other relevant demographic data of minority communities in rural areas.
4. Our AMA will advise organizations of the importance of minority health in rural areas.
5. Our AMA will channel existing policy for telehealth to support improved broadband internet access in minority communities in rural areas to increase the availability of telemedicine where clinically appropriate.
6. Our AMA supports minority health in rural areas through programming, equity initiatives, and other representation efforts.
7. Our AMA encourages the development of strategies and mechanisms for communities to share resources and best practices to serve their rural minority populations. (Res. 433, A-24; Modified: CSAPH Rep. 07, A-25)

Addressing Equity in Telehealth and Health Technology H-480.937

1. Our American Medical Association recognizes access to broadband internet as a social determinant of health.
2. Our AMA encourages initiatives to measure and strengthen digital literacy, with appropriate education programs, and with an emphasis on programs designed with and for historically marginalized and minoritized populations.
3. Our AMA encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations.
4. Our AMA supports efforts to design and to improve the usability of existing electronic health record (EHR) and telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with other mental or physical disabilities.
5. Our AMA encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth.
6. Our AMA supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations.
7. Our AMA supports efforts to ensure payers allow all contracted physicians to provide care via telehealth.
8. Our AMA opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians.
9. Our AMA will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.
10. Our AMA encourages the development of improved solutions to incorporate structured advance care planning (ACP) documentation standards that best meet the requisite needs for patients and physicians to easily store and access in the EHR complete and accurate ACP documentation that maintains the flexibility to capture unique, patient-centered details.
11. Our AMA encourages hospitals, health systems, and physician practices to provide a method other than electronic communication for patients who are without technological proficiency or access. (CMS Rep. 7, A-21; Reaffirmation: A-22; Reaffirmed: Res. 213, A-23; Reaffirmation: A-23; Modified: BOT Rep. 06, I-24)

Closing of Residency Programs H-310.943

1. Our American Medical Association:
 - a. encourages the Accreditation Council for Graduate Medical Education (ACGME) to address the problem of non-educational closing or downsizing of residency training programs.
 - b. reminds all institutions involved in educating residents of their contractual responsibilities to the resident.
 - c. encourages the ACGME and the various Residency Review Committees to reexamine requirements for "years of continuous training" to determine the need for implementing waivers to accommodate residents affected by non-educational closure or downsizing.

- d. will work with the American Board of Medical Specialties Member Boards to encourage all its member boards to develop a mechanism to accommodate the discontinuities in training that arise from residency closures, regardless of cause, including waiving continuity care requirements and granting residents credit for partial years of training.
 - e. urges residency programs and teaching hospitals be monitored by the applicable Residency Review Committees to ensure that decreases in resident numbers do not place undue stress on remaining residents by affecting work hours or working conditions, as specified in Residency Review Committee requirements.
 - f. opposes the closure of residency/fellowship programs or reductions in the number of current positions in programs as a result of changes in GME funding.
 - g. will work with the Centers for Medicare and Medicaid Services (CMS), ACGME, and other appropriate organizations to advocate for the development and implementation of effective policies to permit graduate medical education funding to follow the resident physician from a closing to the receiving residency program (including waivers of CMS caps), in the event of temporary or permanent residency program closure.
2. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to establish regulations that protect residents and fellows impacted by program or hospital closure, which may include recommendations for:
 - a. Notice by the training hospital, intending to file for bankruptcy within 30 days, to all residents and fellows primarily associated with the training hospital, as well as those contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions that minimize undue financial and professional consequences, including but not limited to maintenance of specialty choice, length of training, initial expected time of graduation, location and reallocation of funding, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed.
 - b. Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution.
 - c. Improved provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution.
 - d. Protections against the discrimination of displaced residents and fellows consistent with H-295.969.
 3. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to identify a process by which displaced residents and fellows may be directly represented in proceedings surrounding the closure of a training hospital or program.
 4. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to:
 - a. Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions;
 - b. Create a centralized, regulated process for displaced residents and fellows to obtain new training positions; and

- c. Develop pathways that ensure that closing and accepting institutions provide liability insurance coverage to residents, at no cost to residents. (Sub. Res. 328, A-94; Appended by CME Rep. 11, A-98; Reaffirmed: CME Rep. 7, A-06; Appended: Res. 926, I-12; Modified: CME Rep. 1, A-15; Appended: Res. 310, I-19; Modified: CME Rep. 3, I-20; Reaffirmed: CME Rep. 01, I-22)

International Medical Graduate Employment H-255.965

Our American Medical Association will support federal legislation that reduces the administrative burden and streamlines the process of hiring International Medical Graduates. (Res. 203, I-22)

Expedited H-1B Pathways for International Medical Graduate Physicians in the USA H-255.961

Our American Medical Association supports the continuance of premium processing and other mechanisms that expedite H-1B visa applications and renewals for International Medical Graduate physicians. (Res. 222, A-25)

Urgent Advocacy to Restore J-1 Visa Processing for International Medical Graduate Physicians D-255.969

1. Our American Medical Association publicly advocates to resume the scheduling of new J-1 visa appointments affecting International Medical Graduates.
2. Our AMA will issue urgent advocacy communications to Congress, the Department of Homeland Security, the Department of State, and other relevant agencies, calling for the immediate resumption of J-1 visa processing for International Medical Graduates.
3. Our AME will collaborate with key parties, including program directors, Designated Institutional Officers, medical schools, and healthcare organizations to monitor the impact of visa appointment suspensions on patient care and physician workforce stability.
4. Our AMA will work proactively and transparently to reverse policies harmful to IMGs and mitigate future disruptions, emphasizing the essential contributions of International Medical Graduates to healthcare delivery in the United States. (Res. 237, A-25)

Recognizing and Remediating Payment System Bias As a Factor in Rural Health Disparities H-465.978

1. Our American Medical Association recognizes that systemic bias in healthcare financing has been one of many factors leading to rural health disparities and will advocate for elimination of these biases through payment policy reform to help reduce the shortage of rural physicians and eliminate health inequities in rural America.
2. Our AMA will, as part of our current advocacy for telehealth reform, specify that geographic payment equity be required in any telehealth legislation. (Res. 20, I-21, Reaffirmed: CMS Rep. 6, I-23)

Diversity in the Physician Workforce and Access to Care D-200.982

1. Our American Medical Association will continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools.
2. Our AMA will continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs.
3. Our AMA will continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim

Meeting. (CME Rep. 7, A-08; Reaffirmation A-13; Reaffirmation: A-16; Reaffirmed: CME Rep. 5, A-21; Reaffirmation: Res. 240, A-24; Reaffirmed: Res. 308, I-25)

Increasing Access to Broadband Internet to Reduce Health Disparities H-478.980

Our American Medical Association will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services. (Res. 208, I-18; Reaffirmed: CMS Rep. 7, A-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 2, A-22; Reaffirmed: CSAPH Rep. 2, A-22; Reaffirmed: Res. 112, A-25)

**Appendix A
Rural Health Transformation Program FY26 Funding**

State	FY26 Award Amount	State	FY26 Award Amount
Alabama	\$203,404,327	South Dakota	\$189,477,607
Alaska	\$272,174,856	Tennessee	\$206,888,882
Arizona	\$166,988,956	Texas	\$281,319,361
Arkansas	\$208,779,396	Utah	\$195,743,566
California	\$233,639,308	Vermont	\$195,053,740
Colorado	\$200,105,604	Virginia	\$189,544,888
Connecticut	\$154,249,106	Washington	\$181,257,515
Delaware	\$157,394,964	West Virginia	\$199,476,099
Florida	\$209,938,195	Wisconsin	\$203,670,005
Georgia	\$218,862,170	Wyoming	\$205,004,743
Hawaii	\$188,892,440		
Idaho	\$185,974,368		
Illinois	\$193,418,216		
Indiana	\$206,927,897		
Iowa	\$209,040,064		
Kansas	\$221,898,008		
Kentucky	\$212,905,591		
Louisiana	\$208,374,448		
Maine	\$190,008,051		
Maryland	\$168,180,838		
Massachusetts	\$162,005,238		
Michigan	\$173,128,201		
Minnesota	\$193,090,618		
Mississippi	\$205,907,220		
Missouri	\$216,276,818		
Montana	\$233,509,359		
Nebraska	\$218,529,075		
Nevada	\$179,931,608		
New Hampshire	\$204,016,550		
New Jersey	\$147,250,806		
New Mexico	\$211,484,741		
New York	\$212,058,208		
North Carolina	\$213,008,356		
North Dakota	\$198,936,970		
Ohio	\$202,030,262		
Oklahoma	\$223,476,949		
Oregon	\$197,271,578		
Pennsylvania	\$193,294,054		
Rhode Island	\$156,169,931		
South Carolina	\$200,030,252		