Written Testimony of Jason Shenefield, MBA, FACHE
President and CEO, Phelps Health
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Hearing on "Advancing the Next Generation of America's Health Care Workforce"
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Subcommittee Chairman Buchanan, Ranking Member Doggett, and Members of the Subcommittee, thank you for the opportunity to testify. My name is Jason Shenefield, MBA, FACHE, and I serve as President and CEO of Phelps Health in Rolla, Missouri. I have worked in healthcare for more than 30 years, starting as a Navy Corpsman, and spending my career on the front lines of care delivery – particularly in communities where access is fragile and every staffing vacancy is felt immediately. Today's topic – rural residency development – is not academic for us. It's operational. It's whether families can receive prenatal care close to home. It's whether a senior can receive a same-week appointment for diabetes management. It's whether someone with chest pain has a local physician who knows them before the emergency room ever gets involved. It's our mission: to keep high-quality care close to home.

Background

Since we began operations in 1951, Phelps Health has grown from a small county hospital to a regional health system, providing care to over 200,000 residents across south-central Missouri. Our health system includes several clinics in Rolla and the surrounding communities of Salem, St. James, Vienna, and Waynesville. The six rural counties Phelps Health serves – Crawford, Dent, Maries, Phelps, Pulaski, and Texas – all exhibit significant health disparities related to their rural designation, ranking among the worst counties in the state for health-related factors and outcomes. The regional shortage of qualified physicians, with all six counties being designated Health Professional Shortage Areas (HPSAs) for primary care, is a key reason for these health disparities. This problem is exacerbated by the lack of nearby residency programs to train residents for the unique needs of providing care in rural communities.

Moreover, Missouri has among the highest number of medical schools in the nation, ranking 9th in the nation for total medical school enrollees; however, Missouri only has enough first-year residency slots to cover approximately two-thirds of our medical school graduates. The lack of quality residency slots, related to limited funding availability for rural residency programs, contributes to Missouri ranking among the worst states in the nation for the retention of physicians from medical school.[1] The resulting exodus of medical school graduates discourages these future physicians from beginning practices not only in Missouri, but in rural communities more generally.

Rural residency programs can provide rural communities like ours with greatly needed qualified medical personnel to address health care barriers like geographic isolation, low health literacy and education, and access to preventative care that is covered by a majority of insurance plans. Residents can engage, educate, and serve our rural communities while becoming familiar with the culture and lifestyle of living in a rural area to encourage them to ultimately practice in a rural community following their residency. A high-quality primary care workforce, which includes family medicine physicians, is needed to support the growth of healthy individuals, families, and communities. Primary care providers are on the front lines as the first source of non-emergent care. Through education to manage daily health, treatment for sickness, and linkages to specialized care, primary care providers help people live healthier lives and incur fewer medical costs over time.

Missouri also has several large maternal health deserts, with few or no birthing facilities and limited maternity care providers.[2] Hiring and retaining obstetricians in a rural setting can be challenging as a result of often poorer health system financial viability, increased call, and poorer competitive wages.[10] For this reason, many rural hospitals and health systems have begun to look at family medicine physicians with enhanced obstetrics training as a solution because rural communities do not need a narrow scope, they need physicians who can meet their broad needs safely and sustainably. However, our region does not have any family medicine residency programs with the vast majority of the state's 12 family residency programs being located in metropolitan areas.[3]

Phelps Health moved forward last year to establish a family medicine with enhanced obstetrics (FM/OB) residency program to strengthen the recruitment and retention of primary care physicians in our region. However, this decision was enabled mainly by the award of two planning and development grants from the Health Resources and Services Administration (HRSA) and the Missouri Department of Health and Senior Services that will help cover the substantial start-up costs associated with building a new residency program, including accreditation, faculty development, and recruitment. These grants finally made it possible to move from "planning" to "building". However, limited grant funding is available with only approximately 15 federal awards made each year while very few states offer residency program development grants like Missouri. Meanwhile, Medicare serves as the sustaining force for medical education programs, but those payments currently will not reach us until our first resident steps foot in our facility.

Policy Barriers for Rural Residency Programs

Moreover, we are learning as we move from grant award to implementation that start-up grants are necessary, but insufficient, for building rural residency programs. We are encountering funding gaps that can stall a program even after planning and development grants are awarded. A prime example is the need for a physical facility to meet accreditation requirements. Early estimates for

our buildout are in $5-7 million range. For a rural health system operating at a 2% margin, that kind of capital is not "nice to have" – it's the difference between program launch and limbo.

Once resident training begins, rural residency programs face structural payment challenges that significantly threaten the long-term sustainability of the program. The Medicare direct graduate medical education (DGME) payment, which partially covers the direct operational costs of providing residency training, is driven by a hospital's per-resident amount, its FTE residents, and the hospital's Medicare share of inpatient days. The Medicare indirect graduate medical education (IME) payment, which helps cover additional overhead costs as well as capital costs, is driven by a hospital's ratio of residents to beds and how that hospital is reimbursed by Medicare.

Many rural hospitals, like us, are disadvantaged by each of these factors. First, sole community hospitals and Medicare-dependent hospitals reimbursed at their hospital-specific rate are excluded from Medicare IME payments, which often represent the primary funding source for other prospective payment system hospitals. Recent work has found that, on average, the difference in the per-resident-amount for sole community hospitals paid under their hospital-specific-rate compared with similar sole community hospitals otherwise paid under the prospective payment system, was nearly 50%, or approximately $96,000 per resident per year.[4] That opportunity cost is the difference between a break-even operation and a program that loses money each year.

Second, many rural hospitals interested in starting a residency program have their per-resident-amounts based on earlier cost reports – often 1984 or the first year that residents were trained if there had been an earlier residency program. For Phelps Health, our per-resident-amount was established based on our 1984 cost report, reflecting a time when our healthcare operations and how we engaged Medicare would have looked very different from today. As a result, we have been advised by our residency program financial consultants that our per-resident-amount falls below the national and state median. While we appreciate Congress's recent efforts to allow residency programs to reset their resident FTE caps, no such relief exists for resetting per-resident-amounts.

As a result, fewer than 1 in 6 rural sole community and Medicare-dependent hospitals currently participate in residency programs, let alone develop their own programs, despite comprising nearly a quarter of all rural hospitals.[5,6] It becomes all too easy to see why less than 2% of residency training occurs in rural settings.[7]

When you combine thin rural margins, high-need populations, and graduate medical education funding formulas that often trail where the need is greatest, you arrive at a simple conclusion: Rural residency programs are one of the smartest workforce investments that America can make, but the financing model still leaves too many rural hospitals holding the bag.

Policy Suggestions

I'll close with a few practical, bipartisan solutions that would help rural communities like ours build successful residency programs.

1. Add flexible bridge funding that covers the real-world gaps between a planning grant and a fully function program, especially clinic infrastructure, teaching space, and startup staffing.
2. Create an option for rural hospitals to update their per-resident amount when starting a new rural residency program.
3. Ensure rural facilities are not disadvantaged in Medicare GME payments by allowing rural facilities access to payments if they cannot receive them.

If we can achieve these solutions, we won't just create residencies, we'll create rural physician careers, rural access, and rural stability for generations.

Thank you for your leadership and the opportunity to share Phelps Health's perspective on this topic. We look forward to working with the committee to develop sustainable policy to support rural residency programs like ours across the nation.

References:

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