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Hearing on
"Advancing the Next Generation of America's Healthcare Workforce"
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Chairman Buchanan, Ranking Member Doggett, and Members of the Subcommittee, thank you for the opportunity to testify on the need to modernize graduate medical education (GME) to better meet the nation's current and anticipated workforce and patient-care needs. My name is Dr. Thomas Mohr, and I appear today on behalf of the Sam Houston State University College of Osteopathic Medicine (SHSU-COM) in Conroe, Texas. I serve as the Vice President of Medical Affairs and Dean of the College of Osteopathic Medicine (COM). I'm honored to share my insights on how our nation's GME system works and offer considerations for improvement, including expanding community-based GME, which contributes to the training and experiential learning of physicians and impacts physician distribution and practice.

I have spent my career as an osteopathic internal medicine physician building and supporting residency programs with a strong focus on rural communities, underserved workforce needs and primary care training. I have helped develop and launch 25 new residency programs across five states, while working as a primary care physician and hospitalist in these communities to better understand the whole picture of community health. These individual and collective experiences have made one thing unmistakably clear: our current Medicare GME financing system tends to work very well for large academic medical centers and major hospital systems, but it is structurally misaligned and does not meet the needs of rural communities, smaller hospitals, and the outpatient settings where most Americans receive care.

Our nation's medical education system is essential to preparing the next generation of physicians to help Americans live healthier lives. Therefore, it is essential that we make changes to GME so these future physicians have the education, training, and experiences necessary to meet the needs of the communities where they train and will practice. By modernizing the American GME system we can ensure that we adequately address our nation's chronic disease epidemic and persistent healthcare workforce shortages. This hearing is a timely opportunity to flip the script and update our approach to GME so it strengthens access to care, expands community-based training, and comprehensively prepares the innovative, compassionate workforce our communities deserve to achieve better health and well-being.

I. Overview

Leveraging my osteopathic training and 25 years of experience in GME, my testimony will focus on the following:

- The unique and critical role of osteopathic medicine, osteopathic medical education (OME), COMs, and DOs in providing whole-person primary and specialty care, particularly to patients in rural and other underserved communities and those with chronic disease;

- The way in which our nation's GME system works and areas where I believe it could be improved;
- Examples of how expanded GME in nutrition, health, and wellness and deployment of technology and artificial intelligence in GME can improve Americans' health; and
- Considerations to strengthen our nation's GME system.

II. The Unique Role of OME, COMs, and DOs in Providing Primary and Specialty Care

Osteopathic medicine confers all the benefits of modern medicine to diagnose and treat disease and injury with the added benefit of hands-on diagnosis and treatment of conditions through osteopathic manipulative medicine (OMM) and whole-person health. The geographic distribution and core principles of osteopathic medicine enable us to bolster primary care, rural health, nutrition and wellness, and chronic disease prevention and treatment to improve the health of communities.

Osteopathic Medicine is Grounded in Whole-Person Health

Osteopathic medicine is a philosophy and practice of physician care in the United States, distinct in its whole-person approach and pioneering in its conceptualization of "wellness." Emphasizing prevention, lifestyle-based interventions, nutrition, and functional health is not a new direction for osteopathic education, but a continuation of its foundational principles defined over 150 years ago. For DOs, a whole-person approach includes partnering with patients, considering the connection of body, mind, and spirit in delivering care, and recognizing the role of a physician's hands to diagnose and treat illness or injury. Osteopathic physicians receive more than 200 additional hours of training in osteopathic manipulative treatment (OMT), a hands-on technique that can be used to diagnose and treat musculoskeletal dysfunction, improve mobility, reduce pain, decrease reliance on opioids, and support the body's natural healing.

Emphasis on prevention and wellness is central to a philosophy that promotes the body's natural tendency toward health and self-healing. DOs graduate from medical school and complete specialty training in residency programs and fellowships in hospitals, community health centers, or other clinical settings. Four tenets provide the foundation for osteopathic medicine's whole-person approach:

1. The body is a unit; the person is a unit of body, mind, and spirit.
2. The body is capable of self-regulation, self-healing, and health maintenance.
3. Structure and function are reciprocally interrelated.
4. Rational treatment is based upon an understanding of the basic principles of body unity, self-regulation, and the interrelationship of structure and function.

Osteopathic medicine's patient-centered approach trains DOs to listen closely and look beyond symptoms, considering lifestyle factors like diet and physical activity that influence health and recovery. This emphasis on whole-person patient care prepares physicians to manage chronic conditions, support wellness, and address health at both the individual and population level. This approach equips physicians to care for patients within the context of their daily lives and communities; an essential competency as the nation confronts rising rates of chronic illness and preventable disease. The osteopathic medical tradition holds that a strong foundation as a generalist makes one a better physician, regardless of one's ultimate practice specialty.

GME and Rural Healthcare Are Inextricably Linked

SHSU-COM is one of 46 COMs, comprising 73 campuses, across 36 states that are educating more than 38,000 future physicians. **This represents nearly 30 percent of all U.S. medical students.** Osteopathic medicine is one of the fastest growing health professions. We prioritize advancing whole-person health, delivering primary care, and serving rural and underserved populations; more than half of DOs serve in primary care specialties, where the environment is particularly conducive to patient education and behavioral change to help reduce and prevent chronic disease.[1] We prioritize serving rural and underserved populations who experience disproportionate rates of chronic disease:

- Fifty-six percent of COMs are located in Health Professional Shortage Areas (HPSAs);
- Sixty-four percent of COMs require clinical rotations in rural or underserved areas; and
- Eighty-eight percent maintain a public commitment to rural health.

It is critical that the next generation of physician leaders are competent in patient-centered care, with a focus on primary care, and rural practice. Residency training in areas of need create workforce resiliency.

Emphasizing Community-Based Physician Training

Clinical training in community-based settings helps residents understand the healthcare needs of the population they will ultimately serve. Under this approach, students train in community hospitals, physician practices, health centers, and underserved settings rather than exclusively in academic medical centers. Research shows that where physicians train strongly influences where they choose to practice. More than 73 percent of DOs practice in the state where they do their residency training, and that number increases to 86 percent when they attend both medical school and have a residency in the state.

An effective community-based model is the "hub-and-spoke" approach. This model provides a central academic home while offering experiences across a diversity of community sites, allowing future doctors to have rotations across the full continuum of care and stay connected to local needs. Through direct mentorship from local physicians and healthcare teams, before entering residency, students can gain a deeper understanding of the doctor–patient relationship within the social, economic, and cultural context of each community. In doing so, this model prepares physicians not only to treat disease but to strengthen the health of the communities they serve.

SHSU-COM uses this model with great success in preparing physicians for real-world practice. Students rotate through training sites located in high-need regions such as Texarkana, Beaumont, the Coastal Bend and the Piney Woods regions, learning to deliver comprehensive care in resource-limited environments. Training in rural communities has been shown to mitigate chronic and acute shortages in these areas. With more than half of our graduates entering primary care, and the majority remaining in Texas, this demonstrates the value of hub-and-spoke models to GME to expand community-based experiences.[2]

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[1]American Osteopathic Association, "2025 Osteopathic Medical Profession Report," pg. 5, https://osteopathic.org/index.php?aam-media=/wp-content/uploads/2025-OMP-Report.pdf.
[2] SHSU-COM, "Student Outcomes," https://www.shsu.edu/academics/colleges/osteopathic-medicine/about/student-outcomes.

III. Insights from the Frontlines of GME

Aligning Federal Policy with Community-Based Training Needs

My fellow deans and I are committed to training the next generation of physicians to ensure our nation has the workforce necessary to care for all Americans across their lifespans. To better meet the healthcare needs of underserved communities, we should be training future physicians in community-based settings as training location strongly influences residents will go to practice. Unfortunately, we face an array of challenges, including recruiting, developing, and retaining clinical training sites and clinical faculty. These challenges can be greater for COMs because education often occurs at sites that are more rural, remote, or difficult to access. The role of the distributed model means faculty are maintaining their medical practice and caring for patients while teaching and engaging in research. Although these sites offer the benefits of exposing students to hands-on clinical practice and exposure to the unique needs of a wider range of populations, faculty lack federal financial support compared to academic health centers where they can be supplemented through Medicare funding.

Increasing General GME Funding and Support

From my perspective, the greatest near-term opportunities to grow GME are often in small hospitals and community settings, not in already-saturated major hubs. Unfortunately, those smaller institutions face substantial structural and financial barriers. Most Medicare GME funding remains tied to inpatient hospital financing, despite the fact that most care today occurs in outpatient and community settings, particularly primary care and chronic disease management. Only about 20 percent of physician training occurs in community-based settings, even though 80 percent of hospital admissions take place in hospitals that are not academic medical centers.[3] Rural and critical access hospitals deliver much of the nation's care but receive far fewer GME resources. This imbalance stems from the legacy structure of federal GME funding, which continues to favor large academic medical centers in high-density areas. The current CMS model also relies heavily on residency caps and long-standing allocations that favor incumbents and limit expansion into new programs and rural sites.

For example, per resident amounts (PRAs) vary dramatically by geography based on historical costs, which favors certain regions and legacy systems, while fast-growing states and underserved areas struggle to build sustainable pipelines. Given population migration and current access to care needs, a new approach is warranted. In my home state of Texas, we continue to experience significant population growth due to a combination of births and domestic migration; in 2025, Texas' census increased by 391,243 residents with more than 67,000 people coming from other states and 167,000 individuals from outside the United States. According to federal data, Texas experienced a larger numeric increase in population than other states.[4] Yet, the formulas and funding distributions that CMS uses do not reflect these changes.

The funding caps are especially problematic. I have several community-based hospitals that are interested in starting their first GME program, but because a few residents rotated at those hospitals

[3] Burke LG, Frakt AB, Khullar D, Orav EJ, Jha AK, "Association Between Teaching Status and Mortality in US Hospitals," *JAMA,* 2017;317(20):2105–2113, doi:10.1001/jama.2017.5702.
[4] Community Impact, "Census data: Texas continues to grow, but people are moving here at a slower rate," https://communityimpact.com/austin/south-central-austin/government/2026/02/06/census-data-texas-continues-to-grow-but-people-are-moving-here-at-a-slower-rate.

in the early 2000s for 'elective' rotations from other established residency programs, the hospitals are now capped for future funding. While we appreciate steps taken by CMS to address these caps through reset or redistribution, the process is often too complex and expensive for smaller hospitals to navigate.

Ensuring Medical School Students Become Medical Residents

My job as a dean is not just to educate and train medical students so they can graduate and pass their board examinations but also to assist in their residency placement. As I have emphasized, osteopathic physicians are essential to meeting rural and underserved workforce needs, yet many residency programs impose additional barriers on DO applicants or exclude them altogether. According to National Resident Matching Program data, 29 percent of residency program directors never or seldom interview DO candidates, while nearly three quarters (73 percent) of GME programs that do consider DOs mandate that they take the MD licensure exam, the United States Medical Licensing Exam (USMLE);[5] DO students take the COMLEX-USA for graduation and licensure. There is no medical basis for these policies, as DO and MD degrees and both medical exams lead to unrestricted physician licenses in all 50 states.

Medical school is highly demanding and intensive, and osteopathic medical students are often subjected to an additional 32 hours and $2,345 (as well as prep costs and time) that are required to take the USMLE exam in addition to the COMLEX-USA exam.[6] Several years ago, GME programs were aligned under a single accreditation system, yet evidence indicates that barriers continue to exist.

IV. Expanding Nutrition, Wellness, and Technology into GME

Modernizing GME must address not only where physicians train and how the federal government pays for it, but how future clinicians are prepared to meet today's evolving care needs. The nation's growing burden of chronic disease and preventable illness demands stronger emphasis on prevention, nutrition, lifestyle-based interventions, and whole-person approaches that improve function and long-term health—principles that, as noted earlier, have long defined osteopathic medicine's focus on interconnected systems and patient-centered care. At the same time, GME must prepare physicians to lead in an increasingly technology-enabled healthcare system. Telehealth, remote monitoring, and AI-enabled tools are reshaping care delivery, clinical workflows, and supervision models. Osteopathic medicine has a long history of incorporating innovations into GME, both in the classroom and in clinical experiential learning opportunities.

Advancing Nutrition Education and Food As Medicine

Osteopathic medicine is committed to pursuing comprehensive nutrition education at all stages of physician training, in undergraduate medical education, clinical training, experiential learning, and interprofessional collaboration. The American Association of Colleges of Osteopathic Medicine (AACOM) made a significant contribution to the integration of comprehensive nutrition in April 2024, hosting a Food as Medicine special session at its annual conference. The event reached nearly 1000 medical educators and leaders. By embedding the importance of nutrition into clinical training, the

[5] National Residency Matching Program, "Charting Outcomes: Program Director Survey Results, 2024 Main Residency Match," https://www.nrmp.org/match-data/2024/08/charting-outcomes-program-director-survey-results-main-residency-match/.
[6] USMLE, "Apply for Exams," https://www.usmle.org/apply-exams.

next generation of physicians are prepared to address the root causes of chronic disease and to guide patients in making sustainable changes that support long-term wellness. Further, AACOM has made grants for faculty-led research and curricular innovation aligned with the following principles: nutrition integration across clinical training; curriculum development; experiential learning; interprofessional development; and nutrition counseling. AACOM is now working in partnership with HHS to build on these advancements to ensure that comprehensive nutrition education and training are vertically integrated.

At SHSU-COM, we have employed a full-time PhD Nutrition Scientist since our inception and just last week we cut the ribbon on a new building that will host allied health graduate programs including our SHSU Master's Degree in Nutrition and Dietetics. We continue to expand our opportunity for interprofessional education with a whole-body approach to medicine that incorporates nutrition and physical fitness as well as musculoskeletal optimization.

Deploying Technology and Innovation to Improve Medical Training and Care

Embedding AI and virtual care competencies into GME will ensure physicians can enhance diagnostic accuracy, strengthen population health management, and expand high-quality care to underserved communities. Many programs use AI-assisted platforms that analyze medical imaging (radiology, pathology), identify early disease patterns and risk stratification, and support clinical decision-making. As these technologies evolve, physicians must guide their implementation to ensure adoption strengthens patient outcomes rather than serving solely commercial interests.

In November 2025, SHSU-COM announced the creation of a Medical Artificial Intelligence Institute, designed to advance ethical, patient-centered AI in medical education, research, and clinical care. The purpose of this institute is not to replace physicians with technology, but to ensure physicians lead the responsible development and implementation of AI tools. By grounding innovation in ethics, patient safety, and whole-person care, SHSU-COM is preparing physicians and allied healthcare providers who can evaluate, guide, and improve emerging technologies—particularly in underserved and community-based settings where access gaps remain significant. It is a model for programs nationwide if we want to produce physicians who are clinically skilled, technologically fluent, and ethically grounded leaders in whole-person, community-centered care.

We also believe that AI opens opportunities for new and engaging research within rural and underserved communities. Large urban academic medical centers have long been the focal point for research because the patients come to them, along with their data. We are hoping to leverage the expansive rural and community-based network of physicians that COMs use to train our student doctors and residents to collect and analyze data pools that would have been inaccessible due to cost and infrastructure in the past. We hope that AI may provide the key to unlocking these data sets to improve health and healthcare access for these populations.

V. Considerations to Modernize GME for Current and Future Healthcare Needs

Osteopathic medicine has a proven track record of training physicians who practice primary care in rural and underserved communities. Congress can strengthen the nation's workforce by modernizing Medicare GME to better reflect a community-based, patient-centered training model.

Modernize Medicare GME Financing to Better Reflect Where Physicians Train and Patients Receive Care

Modernizing Medicare GME financing to better reflect where patients receive care—particularly in outpatient, community-based, rural, and underserved settings can advance physician training. Current Medicare GME policy remains disproportionately tied to inpatient hospital-based training, limiting the growth of rural and community-based pipelines.

To be clear, we absolutely need our large urban academic medical centers and their contributions to patient care, research and training cannot be overstated. However, we need to recognize that this model is not the only model, and it has not successfully closed the gap on healthcare access.

To strengthen workforce development, Medicare GME must provide predictable, needs-based support for rural and community training. Legislative proposals like the *Rural Physician Workforce Production Act,* H.R. 1153, would provide additional per-resident payments (PRAs) to rural hospitals when trainees spend significant time in rural settings. Stable, targeted funding is essential for rural hospitals and community programs to recruit faculty and build sustainable training capacity.

Many rural hospitals have PRAs well below the national average, limiting their ability to operate residency programs. Establishing a more uniform approach that increases the PRA for rural hospitals whose rates fall below the national average would provide greater certainty, reduce geographic disparities, and better reflect the higher per-resident costs associated with smaller rural programs.

Increasing Medicare GME funding and the number of residency slots can be targeted to ensure rural and underserved communities receive the physician workforce they need. Larger residency programs benefit from economies of scale, and it is often more expensive to operate smaller programs. CMS funding is provided based on the number of residents, and since the PRA is regionally adjusted, larger metropolitan areas tend to get a larger share. To truly support rural and community-based programs, the added expense of smaller programs needs to be considered.

Reform CMS Slot Distribution Policies That Disadvantage Rural Hospitals

Directing CMS to revise its methodology for awarding new GME slots, including reducing reliance on HPSA scores as the primary prioritization tool, could improve the distribution of future Medicare-created slots. Because rural populations are smaller, modest workforce changes can significantly shift HPSA designations—unintentionally penalizing rural hospitals and limiting their ability to secure new residency slots.

CMS policies should not create additional barriers for smaller programs at a time of acute physician shortages. Congress can play an important role in aligning federal slot distribution policies to better support the development of residency programs in rural and underserved communities.

Consider Removing Barriers to Residency Positions

The bipartisan *Fair Access In Residency (FAIR) Act,* H.R. 2314/S. 2715, increases transparency by establishing two reporting requirements for Medicare-funded GME: report annually on the number of DO and MD applicants and accepted residents, and affirm annually that that applications submitted with scores from the COMLEX-USA are considered. The FAIR Act will help strengthen the physician pipeline and increase access to high-quality, patient-centered healthcare.

Invest in Technology-enabled Training that Expands Care in Rural Communities

Technology can play a critical role in expanding access to GME via tele-precepting and technology-enabled specialty consultation models that expand rural training capacity—allowing residents to train and remain in the communities where they are most needed. Digital care can bridge geographic divides and ensure that physicians are leaders of such programs. The federal government can test models and pilot initiatives to identify the effective approaches and support broader deployment.

VI. Conclusion

Seventy-three percent of DOs practice in the state where they complete residency, and students who train in underserved areas are nearly three times more likely to practice there—and four times more likely to provide primary care. Strengthening community-based GME pathways is essential to addressing workforce shortages and improving access to care.

This Subcommittee has an important opportunity to modernize GME so it supports where Americans actually receive care and where shortages are most severe. We are deeply committed to training physicians through a community-based model that encourages practice in rural and underserved communities and promotes primary care and chronic disease prevention and management, yet Medicare policy too often makes these programs difficult to build and sustain.

I urge Congress to modernize GME by providing payment certainty for new and rural programs, strengthening outpatient and community-based training, reducing residency placement barriers for osteopathic graduates, and expanding technology-enabled training. Thank you for holding this hearing and for the opportunity to testify. I welcome your questions and stand ready to be a resource.