



The Impact of the Budget Reconciliation Act of 2025, H.R.1, on Graduate Medical Education (GME)

Graduate Medical Education Transformation

Legislative Brief approved for sharing: February 25, 2026

Purpose and Action:

The purpose of this review is to educate stakeholders and to communicate the potential impact of H.R.1 on Graduate Medical Education funding with congressional members, state legislatures, and other policy leaders.

Introduction:

The [Budget Reconciliation Act of 2025](#) (H.R.1), passed in July 2025, includes structural changes and cuts to Medicaid that will significantly alter how Graduate Medical Education (GME) programs are funded.¹ The majority of states utilize Medicaid to support GME, helping to fill gaps in other funding sources including CMS Medicare GME. In some states, Medicaid also supports the development of new GME programs in high-need areas such as rural communities.

Changes to Medicaid established through H.R.1 have the potential to reduce states' ability to utilize Medicaid funding at current levels, which could limit new GME program development and lead to closure of existing programs. This brief highlights two areas of particular concern:

1. Lower Medicaid GME through both decreased Medicaid utilization and lower state directed payments, which could reduce the total dollars available for GME.
2. Increased financial strain on small and rural hospitals, which may deter them from pursuing or sustaining GME programs. Specifically, there could be a reduction in income from resident service delivery, which is significant both in the hospital and in provision of ambulatory services. Clinical income often funds half or more of residency program costs, especially in specialties other than family medicine, while GME only pays the "educational" costs.

Lower Medicaid utilization may mean states will need to find other mechanisms to support GME.

Some states use a formula similar to the Medicare formula to calculate Medicaid funding per resident FTE. These formulas usually account for the payor mix of the patient population served. If the Medicaid utilization rate goes down, less funding per resident FTE will be available in these states. For programs that operate at a break even or close to break-even level, this could threaten financial viability. Hospitals considering new GME programs that rely on Medicaid GME funding may choose not to proceed.

In addition, limits on provider taxes (Sections 71115 and 71117) may affect states' ability to leverage federal Medicaid matches for GME.² The Congressional Budget Office (CBO) estimates these provider tax policy changes will reduce federal Medicaid spending by \$226 billion over 10

¹ AAFP, How H.R. 1 Will Affect Family Medicine, podcast and transcript, August 8, 2025. Available at: <https://www.aafp.org/news/podcast/episodes/how-hr1-will-affect-family-medicine.html>

² State Health and Value Strategies, Princeton University, November 2025. Available at; <https://shvs.org/cms-issues-preliminary-guidance-on-provider-tax-grandfathering-and-non-uniform-tax-transition-periods/>



years. A recent KFF report notes that 31 states are expected to experience cuts to existing provider taxes.³ These reductions directly result in lower state funds available for GME funding.⁴

Relevant Provisions in H.R.1

Several sections of the new law may reduce Medicaid enrollment including:

1. New work requirements for Medicaid eligibility (section 71119)
2. Restricting immigrant eligibility (section 71109)
3. Cost sharing requirements for some expansion individuals (section 71120).

Administrative changes may also shift state Medicaid office resources away from GME:

1. More frequent eligibility determinations (Section 71107)
2. Increased requirements for verification of enrollee information (section 71103 and 71104)

Financial Impact on Training Sites

Forty-four states and the District of Columbia utilize Medicaid funding for GME (<https://store.aamc.org/medicaid-graduate-medical-education-payments-results-from-the-2022-50-state-survey.html>). These funds help address their healthcare workforce needs, expand physician training in needed specialties, and sustain existing GME programs. Reduction in Medicaid spending is anticipated to limit healthcare access in physician shortage areas and lead to program closures.

GME is costly, averaging approximately \$230,000 per resident annually, including salaries, benefits, faculty, curriculum, simulation, and testing (Per resident costs for AY 2024 to 2025 is estimated to be \$227,164, with a range of \$190,031 to \$279,631, at the 25th and 75th percentiles, respectively).⁵ While CMS, and to a lesser extent Veterans Administration and HRSA funding, reimburses some expenses, training sites must absorb the remaining costs. These costs are partly offset by the clinical activity of the residents and faculty in the program, directly tied to payor reimbursement for that work. If clinic volume or income decline due to reduced Medicaid coverage, training sites are at high risk of becoming financially vulnerable and unable to continue training residents.

Additional Operational and Educational Risks

Anticipated shifts in patient access also have significant implications for the educational program and ability to train residents in several ways:

- Changes in severity of illness, delayed diagnosis, deferred preventative care and disruption to continuity, and patient volume may limit or challenge training opportunities and jeopardize compliance with ACGME requirements.

³ Kaiser Family Foundation, Five Key Facts About Medicaid and Provider Taxes, December 2025; Available at: https://www.kff.org/medicaid/5-key-facts-about-medicaid-and-provider-taxes/?utm_campaign=KFF-Medicaid&utm_medium=email&_hsenc=p2ANqtz-9UX6tLXMrxtF0UjN8crVr7gRX1U9vwiAySHziaD3djUzbY1mH72-m-ZZk-eaBCzLUNf6c55C3lzZerBKLjZmCKyCD-UA&_hsmi=392377601&utm_content=392377601&utm_source=hs_email

⁴ NRHA, <https://www.ruralhealth.us/nationalruralhealth/media/documents/advocacy/2025/medicaid-provider-tax-guidance.pdf>.

⁵ Regenstein M, Trott J, Ku L, Snyder J, Kepley H, Carter K, Twyman T, Baños J. A New Formula for Teaching Health Center Graduate Medical Education Payments Based on a Comprehensive Cost Evaluation. *Acad Med.* 2025 May 1;100(5):628-634. Available at: <https://doi.org/10.1097/ACM.0000000000005961>.



- Lower Medicaid coverage could hinder recruitment of residents post-graduation, a key strategy for community-based facilities.
- Trainees may struggle to meet required patient encounter thresholds, affecting their readiness for independent practice.

Policy Implications

Expanding and sustaining GME in underserved areas is critical to address the physician shortage and geographic maldistribution. Rural communities, home to one in five Americans (U.S. Census Bureau), face unique challenges in launching and maintaining residency programs.

Policies that affect federal GME funding may impact the future physician workforce and the nation's ability to meet the needs of a growing and aging population. For example, setting minimum residency caps of 16 for rurally located hospitals who participate in graduate medical education could facilitate the growth of rural residency programs funded through Medicare GME.

As healthcare evolves through technology, AI, and policy reform, adequate support for GME is essential to prepare resident physicians to deliver safe, high-quality, and accessible care. Anticipating and addressing the impacts on training the physician workforce of the future, particularly in primary care, is essential to the future of our entire health care system. The effects of HR1 on these impacts must be specifically addressed in legislation regarding health care in this next legislative year.

Stories from the Field

The full impact of these funding changes will not be known for several months. Many programs and institutions anticipating major impacts do not want to be identified publicly for many reasons, some of which are local, and regional shifts and competition in the health care environment where vulnerability may place them at a further financial disadvantage. Additionally, while substantial changes are anticipated, the actual impacts will not be known for months to years because of long financial and audit cycles in health care institutions. We continue to collect these stories and will update this document as we learn more.

Teaching Health Center Programs:

Teaching Health Center programs are based at Federally Qualified Health Centers or other types of community health centers. These health centers often serve a large population of patients using Medicaid and depend on Medicaid reimbursement to financially sustain their centers. We are aware of programs located in Teaching Health Centers that are concerned that reduction in Medicaid coverage for their patient population could dramatically impact their finances directly as well as increase the number of uninsured patients that they see. Several have started discussions about contingency planning if finances continue to deteriorate, including cutting or downsizing the residency program.

Rural Programs:

Rural programs must maintain at least 50% of their training in CMS-defined rural areas to qualify for specific funding through Medicare, which is often essential to adequately funding these programs. We know of several rural programs, including two in the state of Washington, that are considering program downsizing or closure due to concerns about negative financial impacts of the changes to Medicaid eligibility and funding.



Other Established Programs:

Well established programs in urban areas face similar types of decisions. We know of at least one large long-standing program in the state of Washington that has implemented plans to close the program due to projections of budget shortfalls. While the program currently remains open, it will be reevaluated annually. Another similar program in the same state has downsized its program by four residents per year and is considering closing altogether due to the cost of the program.