WHEREAS, resolution H306-A/2018 titled H308-A/2018 STATE GRADUATE MEDICAL EDUCATION (GME) FUNDING ALTERNATIVES was referred to the Bureau of State Government Affairs for updating; now, therefore be it

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED AS AMENDED:

H308-A/13 STATE GRADUATE MEDICAL EDUCATION (GME) FUNDING ALTERNATIVES

The following policy paper and the recommendations provided within are approved to assist the American Osteopathic Association in responding to policy proposals aimed at funding graduate medical education (GME) at the state-level; the AOA will work with the osteopathic community to encourage and support state-level GME funding initiatives that encompass the principles outlined within this paper. (2013).

AOA POLICY PAPER:

STATE GRADUATE MEDICAL EDUCATION FUNDING

BACKGROUND

Physician training requires students to attend four years of medical school, usually paying those costs out-of-pocket or through loans. Following successful completion of medical school, their training continues as medical residents. Medical residents see and treat patients under the supervision of more experienced physicians. This training usually takes place in hospitals though residents often rotate to ambulatory sites such as clinics and physician offices. On average, this residency training takes four years to complete, although highly specialized fields may require longer training.

By and large, overall funding for graduate medical education (GME) comes from patient care revenues. However, the FEDERAL GOVERNMENT IS currently THE single largest SINGLE funder of GME, is the Department of Health and Human Services (HHS) PROVIDING APPROXIMATELY $15.9 BILLION IN FUNDING through the Centers for Medicare and Medicaid Services (CMS) IN 2018. NEARLY TWO-THIRDS OF THIS FUNDING COMES FROM MEDICARE, WITH THE MAJORITY OF THE REMAINDER FUNDED THROUGH MEDICAID. The federal government contributes approximately $15.9 billion in Medicare funds and approximately $2 billion in Medicaid dollars to help pay for GME. Additional funding is provided by the Department of Defense, the Department of Veterans Affairs and the U.S. Public Health Service. In providing Medicare funding, Congress has acknowledged that training physicians is a public good. Despite that acknowledgement, there have been periodic calls to remove GME from Medicare and Medicaid and secure other sources of funding. So far, Congress has neither acted on these recommendations nor
have other entities stepped up to assume a greater share of the financial responsibility (relative to Medicare or Medicaid) for physician training.

With calls to reduce federal spending, **WITH CAPS ON THE FEDERAL BUDGET, GME FUNDING HAS BEEN AND WILL CONTINUE TO BE RELATIVELY FLAT.** ADDITIONALLY, is potentially faced with a significant reduction in funding. The Obama - **THE TRUMP** Administration and several members of Congress have **HAS** spoken out in favor of **SUPPORTED BOTH CONSOLIDATION AND REDUCTION** OF GME funding as part of a comprehensive approach to reducing overall federal spending. Additionally, **IN DECEMBER 2018, THE CONGRESSIONAL BUDGET OFFICE ISSUED RECOMMENDATIONS TO CONSOLIDATE AND REDUCE FEDERAL PAYMENTS FOR GME AT TEACHING HOSPITALS,** several bills have been introduced at the federal level that attempt to address GME funding shortages. Conversely, medical schools, hospitals and medical associations see a need to increase funding and residency slots to help train physicians and fill projected workforce shortages and are working at both the state and federal levels to achieve increased funding for GME.

There are two mechanisms **THROUGH** which Medicare and Medicaid distribute GME funding: direct medical education (DME) and indirect medical education (IME) payments. DME payments are based on resident salaries, supervision and other educational costs. IME payments are based on additional operating costs of a hospital with a GME program. One of the greatest **OBSTACLES TO federal GME funding** is the Balanced Budget Act of 1997 (**BBA**), which limited the number of allopathic and osteopathic residents a hospital can count for purposes of DME and IME payment. The law also reduced the IME multiplier over a four-year period, however, the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (**BIPA**) delayed the IME reduction. Additionally, the Budget Control Act of 2011 enacted a series of automatic budget cuts that included a 2% cut for IME payments **WHICH TOOK** taking effect on April 1, 2013.

**MEDICARE**

The formula for determining Medicare payments to hospitals for direct costs of approved GME programs is established in section 1886(h) of the Social Security Act (**the Act**). A DME payment is determined by multiplying a hospital-specific, base-period per resident amount by the weighted number of full-time equivalent residents working in all areas of the hospital and the hospital’s Medicare share of total inpatient days. The Affordable Care Act amended section 1886(h)(4)(E) to allow a hospital to count residents training in non-hospital settings if the residents are engaged in patient care activities and if the hospital incurs the costs of the stipends and fringe benefits of the resident during the time residents spend in that setting.

As previously mentioned, IME payments are based on additional operating costs of a GME program. The factors for IME payment generally include sicker/more complex patients, maintaining stand-by capacity for certain specialized services (e.g. burn units), residents ordering more tests and trainees being less efficient in providing care. IME payments provide for the legitimate increase in costs training hospitals incur. IME payments are calculated by adding the individual intern/resident-to-bed ratio into...
a formula already established in the Medicare statute. The current IME adjustment is calculated using a multiplier set at 1.35, which means that a teaching hospital will receive an increase of approximately 5.5% in Medicare payments for every 10-resident increase per 100 beds.

**MEDICAID**

Despite **FEDERAL LAW NOT REQUIRING STATE MEDICAID PROGRAMS TO SUPPORT GME**, being under no obligation to do so, Medicaid is the second largest **FUNDER OF GME** programs. Several **A MAJORITY OF** states have implemented mechanisms within their Medicaid programs to supplement federal funding of GME. In most cases, Medicaid GME funding is structured similarly to Medicare, providing direct and indirect payments. The most recent data available estimates that Medicaid paid **APPROXIMATELY $4.33-3.87 billion** to GME programs in 2015, up from **$3.87-3.78 billion** in 2012. **From DESPITE THE FACT** that **MUCH OF THAT FUNDING** came from matching federal payments, **THREE STATES REPORTED THAT THEY EXPLICITLY REDUCED THEIR MEDICAID SPENDING ON GME, AND ANOTHER SEVEN REPORTED AT LEAST A TEN PERCENT REDUCTION IN MEDICAID GME PAYMENTS BETWEEN 2012 AND 2015.** However, several states have reduced their funding for GME programs through their Medicaid programs.

In 2005, 47 states provided $3.18 billion through Medicaid to support GME. By 2015, only 42 states and the District of Columbia (DC) supported GME through their Medicaid program. Arizona, Massachusetts, Montana, Rhode Island, Vermont and Wyoming have since ended GME funding, citing budget shortfalls, **AND ALABAMA, MICHIGAN AND TENNESEE REPORTED THAT THEY RECENTLY CONSIDERED ENDING FUNDING AS WELL.** Additionally, some states like Iowa, Michigan, Oregon and Pennsylvania, have discussed ending Medicaid support for GME. **OTHERS, LIKE FLORIDA AND WASHINGTON, HAVE DECREASED MEDICAID FUNDING FOR GME IN THE LAST FEW YEARS.**

**Medicaid Fee-for-Service**

Forty states and the District of Columbia make DME and/or IME payments under the Medicaid fee-for-service program. A fee-for-service program is a payment model where services are unbundled and paid for separately. **Twelve FOURTEEN states and DC fund DME and/or IME programs using a calculation method similar to Medicare’s GME funding formula, SOMETIMES IN ADDITION TO OTHER METHODS.** The remaining states calculate payments by “some other method,” which usually includes a variation of a per-resident or lump-sum amount. The per-resident or lump-sum amount **ARE** is based on the “hospital’s share of total Medicaid revenues, costs or patient volumes.” **TWENTY-NINE STATES REPORTED CALCULATING PAYMENTS SOLELY BY “SOME OTHER METHOD” IN 2015.**

**Medicaid Managed Care**

Capitated managed care is a state’s use of risk-based capitation payments within their Medicaid program. This typically includes contracting with one or multiple managed care organizations (MCOs) to administer the Medicaid program for a defined population of Medicaid patients. **Thirty NINE states and DC use capitated Medicaid managed care programs. Currently, 23 states and DC included DME and/or IME payments under their Medicaid managed care programs.** **FOURTEEN SIXTEEN states and DC directly pay teaching hospitals or other teaching programs under Medicaid for DME and/or IME payments.** **This REPRESENTS an INCREASE in the number of states who have made direct payments under managed care SINCE 2012.** States who make direct Medicaid payments indicate **THAT they wish to help train future physicians who will service Medicaid beneficiaries and that using Medicaid funds to fund GME programs will help advance state**
health policy goals. Five of these states pay for both DME and IME costs and three states do not distinguish between the two costs.\textsuperscript{24}

\textbf{Nine Twelve} states recognize and include Medicaid DME and/or IME payments in their capitated payment rates to managed care organizations. Five \textbf{Half} of these states – \textbf{Iowa}, Kansas, Kentucky, Michigan, \textbf{Minnesota} and Washington, \textbf{Mississippi} – require MCOs to distribute the negotiated payments to teaching hospitals. The other \textbf{Four SIX} assume MCOs will distribute the payments.\textsuperscript{25}

\textbf{ALIGNING GME FUNDING WITH HEALTH POLICY PRIORITIES}
States continue to look to align GME funding with other health policy goals. This can include increased funding for training in certain specialties, addressing workforce shortages in rural and underserved areas and increasing faculty positions to train new physicians. \textbf{A 2016 STUDY REVEALED THAT THIRTY-TWO STATES LINKED MEDICAID GME PAYMENTS TO A STATE POLICY GOAL OF INCREASING THE SIZE OF THE PHYSICIAN WORKFORCE, COMPARED TO 22 STATES IN 2012.}\textsuperscript{26}

\textbf{Kansas and Florida AND KANSAS}
In an effort to promote accountability in the use of GME funds, \textbf{Kansas and Florida AND KANSAS} link Medicaid GME payments to stated state policy goals. \textbf{Kansas IN FLORIDA, THIS applies} to both fee-for-service (FFS) and managed care Medicaid programs, while \textbf{Florida KANSAS GME payments focus ES SOLELY} on fee-for-service FFS payments.\textsuperscript{27} Like most states, \textbf{Kansas and Florida AND KANSAS} have focused on encouraging training in primary care specialties \textbf{AND INCREASING ACCESS TO CARE IN} rural and medically underserved areas.

\textbf{Kansas also uses GME payments} to promote an increased supply of physicians serving the Medicaid population, and \textbf{FUNDS TEACHING HOSPITALS AS WELL AS TEACHING SITES IN NON-HOSPITAL SETTINGS}, increase the geographic distribution and fund teaching hospitals that have experienced GME funding cuts through the Medicare program. \textbf{IN FLORIDA, GME PAYMENTS HAVE BEEN EXTENDED TO INDIVIDUAL TEACHING PHYSICIANS UNDER FFS, IN} addition to Medicare and Medicaid GME funding, Florida also \textbf{THE STATE ALSO} uses alternative sources to fund residency programs \textbf{IN ADDITION TO MEDICAID AND MEDICARE, INCLUDING THE STATEWIDE MEDICAID RESIDENCY PROGRAM AND THE GRADUATE MEDICAL EDUCATION STARTUP BONUS PROGRAM} serving Veterans Administration medical, loan repayment for residents and physicians serving underserved or designated shortage areas after training, and offers state appropriations for additional funding to encourage new training opportunities and cost/resource sharing between groups.\textsuperscript{28} \textbf{THE FORMER WAS CREATED IN 2013 WITH $80 MILLION IN RECURRING STATE AND MATCHING FEDERAL FUNDS TO SUPPORT PAYMENTS TO HOSPITALS WITH ACCREDITED RESIDENCY PROGRAMS, WHILE THE LATTER WAS CREATED IN 2015 WITH $100 MILLION AlLOCATED TO EDUCATING AND TRAINING PHYSICIANS IN SPECIALTIES WHICH ARE IN A STATEWIDE DEFICIT. IN 2018, THE FLORIDA LEGISLATURE APPROPRIATED $242.3 MILLION TO THESE PROGRAMS.}\textsuperscript{29}

\textbf{Florida’s Community Hospital Education Act} also provides funding intended for primary care specialties. This program appropriates state funds into the Medicaid program, with hospitals being paid directly from this fund to help support primary care specialty interns and residents.\textsuperscript{30}

\textbf{Texas}
In 2014, 2007, the Texas legislature \textbf{ALLOCATED $12 MILLION TO SEVERAL INITIATIVES WHICH TOGETHER CREATED 100 NEW RESIDENCY POSITIONS ACROSS NINE}
NEW PRIMARY CARE AND TWO NON-PRIMARY CARE PROGRAMS. In 2015, the legislature consolidated these initiatives into a single GME expansion program, to which it appropriated $49.5 billion biennially. This resulted in an increase in per-resident funding from $65,000 to $75,000 per year and the creation of 130 new residency positions in 2016-2017. Authorized an additional $62.8 million in state funding for GME positions and for faculty costs. However, the additional funding was not enough to pay for the growth necessary to keep up with the physician shortage. Texas saw a 50% cut in its GME funding in 2012-2013. Per capita formula funding cut $25 million from its budget, now spending $4,400 per resident from $6,600. The Texas Higher Education Coordinating Board (THECB) family medicine residency funding saw a significant $15.6 million cut, from $21.2 million to $5.6 million. THECB Primary Care Residency Program ($5 million) and THECB GME Program ($600,000) were both cut altogether. Finally, the Physician Loan Repayment Program was cut by $17.7 million, from $23.3 million to $5.6 million.

Since 2009, the Texas Health and Human Services Commission (HHSC) has also provided supplemental funding to five state-owned teaching hospitals for approved medical residency training programs. In the Texas Administrative Code, the Texas Health and Human Services Commission (HHSC) reimburses approved state-owned or state-operated teaching hospitals, the EACH hospital directly using a calculation that is based upon the hospital's self-reported Medicaid inpatient days and resident full-time equivalents. HHSC also separately provides IME payments to teaching hospitals to offset their higher patient care costs relative to non-teaching hospitals, including costs related to supervising and maintaining resident records. The inpatient direct GME cost for hospital cost reports. The costs are calculated using a similar method as set out in Title XVIII of the Social Security Act.

These increases follow years of cuts to GME funding, including a 50% cut in 2012-2013, which led to the elimination of the Texas Higher Education Coordinating Board (THECB) Primary Care Residency Program and the THECB GME program in 2019.

In 1997, Utah created the Utah Medical Education Council (UMEC) to address the state’s physician shortage and coordinate GME funding that would be better aligned with the state’s workforce needs. UMEC is a quasi-governmental body whose responsibilities include assessing the physician workforce demands, developing and suggesting policy, finding and disbursing GME funds, addressing physician shortages in rural locations and managing the GME funds from CMS.

To better address the state’s GME funding needs, Utah applied for, and was granted, a CMS waiver that placed GME funding into a funding pool, rather than directing money to hospitals. By pooling all of the state’s GME funding, UMEC was able to distribute the funds directly to hospitals and programs based on specific workforce needs and objectives. The waiver resulted in a 29% increase. The waiver has had noticeable results: the number of residents in Utah increased 29% between 1997 and 2007, from 442 residents in 25 programs to 568 residents in 30 programs. Training hospitals and programs are now accountable to UMEC for how the GME funds are spent. UMEC also worked with training programs to encourage residents to practice in Utah. Workforce coordination efforts also identified new rural training opportunities in areas like family medicine, general surgery, internal medicine, pediatrics and psychiatry. The waiver ultimately ended on June 30, 2010. According to UMEC’s most recent (2016) report, the state has
AVERAGED 202 RESIDENTS PER YEAR BETWEEN 2006 – 2016, REPRESENTING AN APPARENT DECLINE FROM LEVELS UNDER THE WAIVER.  

ADDITIONAL GME FUNDING MODELS

There are several other GME funding models that have the potential to provide revenue for GME programs. These models differ based on who would receive payment, how funds would be allocated among recipients, what mechanisms would be needed to assure accountability and whether payment would be linked to the achievement of specific performance measures. These models are not mutually exclusive and could be combined to enhance stability and accommodate GME policy objectives. In some cases, a combination of several models would be necessary to pay for different kinds of costs to address specific educational or workforce objectives.

All-Payer System

The SEVERAL STATES HAVE EXPERIMENTED WITH VARIATIONS ON AN all-payer system, WHICH COMBINES FUNDING FROM ALL PUBLIC AND PRIVATE SOURCES TO PAY FOR STATE GME PROGRAMS, has proven to work in several states BUT ONLY MARYLAND’S IS CURRENTLY OPERATIONAL. The AOA’s Physician Education Advancing Community Health (PEACH) program is an example of a payor funded program whereby Health Maintenance Organizations would help fund GME. ALTHOUGH PRIVATE PAYORS RARELY FINANCE GME DIRECTLY, THE HIGHER RATES THAT THEY PAY TO TEACHING INSTITUTIONS HELP TO SUBSIDIZE GME PROGRAMS. The extents to which private insurers help fund portions of residency training and costs are nearly incalculable. The nonprofit RAND Corporation did a survey-based study in 2006 and found that private payers, like insurance companies, indirectly fund about 43% of the costs associated with training physicians. However, hospitals tend not to negotiate for physician training costs when they contract with private insurers.

Maryland IMPLEMENTED THEIR currently has an all-payer system IN 1977. PRIOR TO 2014, THE STATE USED A PROSPECTIVE, DIAGNOSIS-BASED PAYMENT MODEL, WHICH KEPT THE RATE OF INCREASED SPENDING PER ADMISSION BELOW THE NATIONAL RATE, ALTHOUGH IT WAS LESS SUCCESSFUL AT CONTAINING OVERALL HOSPITAL SPENDING DUE TO INCREASED ADMISSION RATES. SINCE 2014, MARYLAND HAS USED A PAYMENT MODEL THAT REQUIRES EACH HOSPITAL TO MONITOR BOTH THE NUMBER AND COST OF ADMISSIONS, where the PAYMENT RATES ARE ESTABLISHED BY THE QUASI-GOVERNMENTAL Health Services Cost Review Commission, AND ALL PAYORS MUST PAY A GIVEN HOSPITAL THE SAME RATE FOR THE SAME SERVICE, BUT EACH HOSPITAL NEGOTIATES ITS OWN RATES.

Maryland has built costs associated with GME funding into its rate-setting system, AS WELL AS SURCHARGES TO SUPPORT AN “UNCOMPENSATED CARE POOL” AND A PUBLIC PLAN FOR RESIDENTS WITH CHRONIC HEALTH CONDITIONS, INTO ITS RATE-SETTING SYSTEM. The rates for graduate medical education are reviewed on an annual basis based on financial and resident count reports. Maryland also has a Medicare waiver THAT ALLOWS IT TO SET MEDICARE PAYMENT RATES, HISTORICALLY, in which the federal government pays more in Maryland than anywhere else. In return, Maryland has D to keep its Medicare costs below national growth FOR HOSPITAL PAYMENTS PER ADMISSION IN ORDER TO MAINTAIN ITS WAIVER, BUT THE TEST UNDER THE CURRENT WAIVER FOCUSES ON THE PER CAPITA GROWTH IN HOSPITAL SPENDING. Maryland is currently in jeopardy of losing its waiver due to federal sequester concerns.
New York **PREVIOUSLY OPERATED AN** all-payer system **THAT** was created through the “Professional Education Pool” which collects and distributes money for GME. New York requires all payors to contribute to the fund, including Blue Cross and Blue Shield, commercial insurers, health maintenance organizations (non-Medicaid and non-Medicare), businesses, self-insured funds and third party administrators. There are two ways for payors to make payments: first, by voluntarily contributing an amount based on per covered life of the individual or family; or if no direct contribution is made, a surcharge on each payment of inpatient costs plus a 24% differential LEVIED A “COVERED LIVES ASSESSMENT” TAX ON PRIVATE HEALTH INSURERS BASED UPON MEMBER FEES BY REGION AND TYPE OF INSURANCE. The Professional Education Pool monies are collected in a trust fund and distributed to teaching hospitals on a monthly basis in accordance with their adjusted share of the region’s total GME spending. THE MONEIES COLLECTED WENT INTO TWO POOLS, ONE THAT SUBSIDIZED CARE FOR INDIVIDUALS WHO WERE UNABLE TO PAY AND ANOTHER THAT FUNDED GME. IN THE LATE 2000S, HOWEVER, THE GME FUNDING POOL WAS REALLOCATED TOWARD UNCOMPENSATED CARE IN TEACHING HOSPITALS, AND OTHER “HIGH PRIORITY” ITEMS. **44**

**Health Care Provider Model**

Medicare pays for GME through a health care provider model. This approach links payments for clinical training to patient care activities. Because the indirect payment adjustment is intended to reflect the impact of teaching activity on a hospital’s patient care costs, this model is particularly appropriate for IME payment.

Several variants of this model have been proposed to encourage more training in nonhospital settings. These variants include a direct pay approach whereby payment would follow the resident training in a nonhospital site; pro rata payment of hospitals and nonhospital sites based on agreements among the entities or a fixed allocation developed in accordance with national cost data; or payment to the entity that bears substantially of the costs of the nonhospital rotations. The first two variants would create substantial administrative burdens. Although less burdensome and disruptive, the third option appears less likely to achieve its stated goal. A voucher or “set-aside” system also could be established whereby a specified share of payment for direct training costs would be earmarked for nonhospital settings.

The principle advantage of the provider model is that regulatory, cost reporting, auditing and compliance mechanisms already are in place and well established. To this extent, these mechanisms have created persistent problems, which is also a disadvantage. This model also fails to provide financial support for training that occurs outside of patient care settings (e.g., much of the training in preventative medicine).

**Education Model**

Under this approach, payment would be made to a program sponsor, which would be held accountable for the way funds are allocated and expended. Sponsors could be universities, medical schools, colleges of osteopathic medicine, hospitals, consortia or any other entity whose primary purpose is providing education and/or health care services (e.g., a health department, public health agency, organized health care delivery system or hospital system.) Because this model treats direct GME costs as costs of education not patient care, adherents suggest that greater weight will be placed on educational needs as training decisions are made. In return for payment, the program sponsor (or its designees) would assume all (or substantially all) of the direct costs of operating the GME program. Allocation of GME costs and payments would be established through written agreements between the sponsor and clinical training sites. Because IME is a hospital cost, this model would not provide an adequate basis for IME payment.
The principle advantage of this approach is its focus on education. Unfortunately, it also would require a major shift in program accountability and funding, particularly when training occurs in community teaching hospitals rather than academic medical centers, where medical schools and hospitals are linked through common ownership or other longstanding corporate or strategic ties. This approach could also discourage hospitals from maintaining or starting GME programs.

As a variant to this model, vouchers could be given directly to residents so that they could purchase their own GME. Unlike the vouchers mentioned in conjunction with the provider model, these vouchers would permit residents to control funding for their graduate training, allowing monies to flow to all training sites. In theory, this approach would enhance competition among GME programs. It is not clear, however, how much effect it would have because programs already compete for residents and rotation sites.

Besides the disadvantages mentioned above, this approach would require a new regulatory mechanism for determining which residents qualify for funding and how many positions would be funded. It also fails to address national physician workforce needs or to assure that adequate resources are available in needed specialties and geographic areas. Implementing this approach could result in substantial year-to-year fluctuations in program size, undermining the stability of existing programs and making faculty and resource allocations difficult. Residents could also be hard pressed to hold their programs accountable once training decisions are made.

Planning Model
Under this approach, funding would be channeled through planning or coordinating bodies such as GME consortia, state GME, physician workforce commissions or task forces. The primary function of these bodies would be to assess the health care needs of their communities and to allocate funds based on local workforce considerations.

Because this approach ties training and funding decisions to local health care needs, it could provide the states, payers and consumers a stronger role in allocating funds to meet workforce objectives. According to the Council on Graduate Medical Education, however, existing evidence tends to suggest that reliance on consortia to assume such a role may be premature. Adopting this model would also require development of a new regulatory mechanism to assure accountability. Payment to state entities or consortia provides little incentive to nonteaching hospitals to initiate new GME programs.

Performance Model
This model links payment to the achievement of specific performance measures or objectives. Funding could also be used to support specific projects or demonstrations on infrastructure development or particular workforce goals.

While this approach encourages innovation and quality enhancement, it is more suitable as a supplemental funding mechanism than as a primary source of GME payment. This model is also dependent on well-defined quality measures and workforce priorities. Neither may be sufficiently well developed to support all GME funding decisions at this time. This approach could also result in substantial year-to-year fluctuation in payments if all funding decisions are based on meeting specific performance measures.

CONCLUSION
With federal and state budgets look to cut spending, GME programs are particularly vulnerable. AOA policy, “affirms its support for maintaining and enhancing the quality of teaching programs.” As states address shortfalls in federal GME funding, the AOA encourages all viable models to be examined.

While all-payor systems have proven effective in some states, each state is different and may require its own unique GME funding system. Additionally, as states and the federal government implement health
insurance exchanges, we encourage the exploration of using a portion of any health plan surcharge to fund GME. This will help address concerns related to workforce shortages as the covered population grows.

The AOA supports states creation of alternative GME funding mechanisms and the alignment of this funding with their states health care priorities. Most important, within these priorities are training those specialties with the largest workforce shortages and providing care to those residents in the greatest needs (those in rural and underserved areas).

The AOA believes that state GME funding must account for osteopathic programs that incorporate the holistic approach to medicine, including the promotion of osteopathic principles and tenets.

The AOA believes that state GME funding should focus on programs that address comprehensive health care systems that deliver care through a variety of settings. This includes training residents in hospitals, rural clinics, community-based centers and patient-centered medical homes. These programs should also provide training in advancing technologies within the delivery of care.

The AOA believes that state GME funding should emphasize the importance of both basic and clinical research in an effort to advance the practice of medicine and the care patients receive.

The AOA supports the physician-led, team-based model of care. The AOA believes that state GME funding should promote this model of care by promoting interprofessional education, so that physicians can not only learn to lead the health care team, but also better understand the skills and abilities each member brings to that team.

Finally, this policy is intended to complement AOA Policy, H252-A/04 RESIDENCY TRAINING SLOTS. The PEACH program H329-A/2016 GRADUATE MEDICAL EDUCATION FUNDING AND INCENTIVES represents one advocacy tool developed to assist states in developing alternative GME financing, and the AOA should continue to create additional resources that support the osteopathic community in ITS efforts to provide adequate GME funding.

References
3. Id.
4. Id.
6. Consolidate and Reduce Federal Payments for Graduate Medical Education at Teaching Hospitals, supra.
10. Id.


16. *Id.*

17. Metzler, *supra*.


19. *Id.*

20. *Id.*

21. *Id.*


23. *Id.*


25. *Id.*

26. *Id.*

27. *Id.*

28. *Id.*


30. *Id.*


33. *Id.*

34. *Id.*

35. *Id.*

36. *Id.*


39. *Id.*

40. *Id.*

41. *Id.*


44. AOA Policy H319-A/15.

Explanatory Statement:

ACTION TAKEN _________________________

DATE ______________________________