

Putting the Roadmap to a Comprehensive State Graduate Medical Education Strategy into Practice: State Perspectives

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ABSTRACT

Physician workforce shortages are limiting access to health care in nearly every state, with underserved and rural areas facing the greatest shortfalls. The case examples herein highlight how three states — Missouri, North Carolina, and Wisconsin — are planning and implementing aspects of their tailored state graduate medical education strategies, as outlined in [A Roadmap for Building and Implementing a Comprehensive State Graduate Medical Education Strategy: Actionable Steps to Align Investments with Workforce Needs](#). Each state strategy has its own objectives, such as filling the medical school–residency training gap or sustaining a rural workforce, yet offers insights for other states planning a “grow your own” approach to expanded residency training.

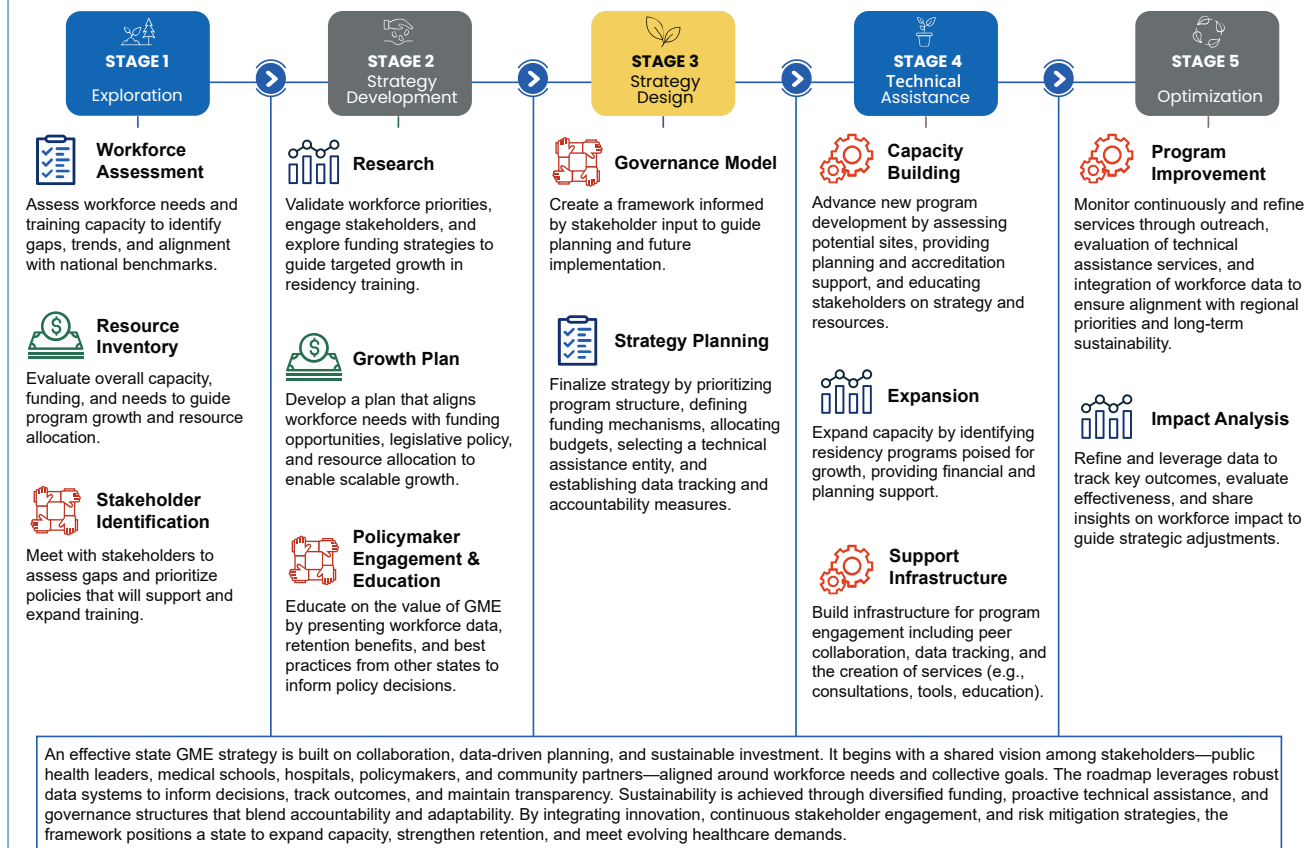
INTRODUCTION

Physician workforce shortages are limiting access to health care in nearly every state, with underserved and rural areas facing the greatest shortfalls.¹ To become board certified and licensed to practice, a physician must complete residency training after medical school. Research demonstrates physicians are likely to practice near where they train, and this evidence has encouraged states to adopt a “grow your own” strategy to expand residency training, also known as graduate medical education (GME), with the intention of retaining physicians in-state after residency.^{2–4}

Graduate medical education (GME) is the required training physicians complete after medical school to practice in a specialty. GME includes residency and fellowship training that varies in length by specialty. GME is paid employment in a structured, closely supervised clinical training environment.

Addressing physician workforce shortages requires a coordinated statewide approach. States play a key role in shaping GME not only as funders but as workforce planners and conveners. [A Roadmap for Building and Implementing a Comprehensive State Graduate Medical Education Strategy: Actionable Steps to Align Investments with Workforce Needs](#) provides states with an evidence-based framework that organizes a GME growth strategy into five iterative stages.⁵

A Roadmap for Building and Implementing a Comprehensive State GME Strategy



Examining existing state approaches to expanding and sustaining GME capacity offers valuable insights into how states can design and finance GME to meet population health needs and how state investments can complement federal efforts to expand the workforce and enhance care in underserved communities. Federal investments total more than \$28 billion annually and are primarily funded through Medicare, with substantial contributions from Medicaid, the US Department of Veterans Affairs, the US Department of Defense, and the Health Resources and Services Administration.⁶

This report summarizes state case examples, presenting state trends in physician supply, the number of physicians practicing in key specialties, and the distribution of physician training sites in the state. (These data are sourced from [the Carolina Health Workforce Research Center](#),⁷ [the North Carolina Graduate Medical Education Technical Assistance Center](#),⁸ the [Missouri Department of Health and Senior Services](#),⁹ and the [Wisconsin Collaborative for Rural Graduate Medical Education](#).¹⁰)

Each case also includes a summary of current progress on the state's development, implementation, and evaluation of a tailored state GME strategy, informed by state framework developers and administrators. These state case studies, along with Table 1 from [A Roadmap for Building and Implementing a Comprehensive State Graduate Medical Education Strategy](#),⁵ illustrate models states have used to grow GME capacity, strengthen the health workforce, increase access to care, and address critical population health priorities.

MISSOURI: HIGHLIGHTING A NEW STATEWIDE STRATEGY TO BRIDGE THE MEDICAL SCHOOL-RESIDENCY TRAINING GAP

The need

Missouri is estimated to need an additional 2,157 physicians, as of 2026, to meet current health demands. While the state ranks ninth nationally for producing medical school graduates, it lacks sufficient residency positions, creating a gap that leads medical students to leave the state for residency training. In 2023, there were 1,062 medical school graduates, yet only 705 first-year GME slots.¹¹ This mismatch, combined with 111 of the state's 114 counties being designated as Health Professional Shortage Areas, underscored the need for a comprehensive state strategy.¹²

The strategy

Missouri uses its GME program, launched in 2023, to implement and expand its statewide strategy to address physician workforce gaps.⁹ The state began its planning by quantifying the physician pipeline gap and identifying the maldistribution of the workforce, particularly in rural areas, through an inventory of in-state GME programs. It also built relationships with state leaders and national experts (Stage One of [A Roadmap for Building and Implementing a State Graduate Medical Education Strategy](#)). Missouri's plan relied on strong governance and collaboration with legislators and policymakers, Medicaid, hospital and primary care associations, physician specialty groups, rural health advocates, and higher education leaders. Regular meetings fostered joint learning about GME complexities and opportunities, while national consultants provided guidance (Stage Two). In addition to these efforts, Missouri's Medicaid program provides ongoing support for all GME training in the state through a supplemental payment mechanism, which evolved to include both direct GME and indirect GME payments. The Medicaid funding helps stabilize GME financing for hospitals and ensure continuity of training programs (Stage Three).

The resulting statewide strategy prioritized closing the medical school-residency gap; training in primary care, high-need specialties, and a targeted curriculum (e.g., addiction and nutrition); providing rotations in rural and underserved areas; offering competitive grants for sustainable program development; and providing state-based technical assistance. This work corresponded with bipartisan support for the passage of HB 1162.¹³ This bill gives the Missouri Department of Health and Senior Services (DHSS) the responsibility and statutory authority to implement the first GME slot-expansion grant program for high-need specialties, allowing programs that have established Medicare funding caps to grow, with an initial \$2.3 million appropriated in 2023 (Stage Three).¹³

Funding

With a plan established and funding secured, DHSS allocated staff, including a dedicated GME Coordinator, and formalized governance through the Missouri GME Advisory Committee in 2025 (see Figure 1). The program received \$2.3 million in 2023 and \$10 million in 2024 — drawn from general revenue and opioid settlement funding — to provide state-based technical assistance, start new programs and rural tracks in facilities eligible for sustainable Medicare

"Our health care workforce shortage is a public health crisis. Missouri is short over 2,100 physicians, with concerning geographic imbalances across the state. We are working in a unified, bipartisan way to remedy that, particularly for our rural and underserved communities. This is a fixable problem — one resident slot at a time, with a strategic plan for sustainability and a positive return on investment." — Heidi B. Miller, MD, Chief Medical Officer, Missouri Department of Health and Senior Services

funding, and add GME curricular enrichment opportunities in rural and addiction education (Stage Three). Building on the success of new rural programs launched through the federally funded Rural Residency Planning and Development program, the state made additional investments to expand training in family medicine, internal medicine, pediatrics, psychiatry, obstetrics/gynecology, and general surgery.

Implementation

DHSS convened the first statewide GME Summit in 2025, uniting stakeholders who had never collaborated before, and established an in-state GME Technical Assistance Center (TAC) to provide expertise and sustain momentum (Stage Three, Stage Four). The TAC now serves as Missouri’s hub for GME support, networking, and program sustainability (Stage Three, Stage Four). The center focuses on supporting capacity building, working with new grantees to support planning and GME development, and identifying existing programs in need of additional support. Moving forward, DHSS and the TAC will monitor outcomes, optimize the physician pipeline, and strengthen retention strategies to ensure Missouri meets its workforce needs efficiently and compassionately for the state’s trainees and citizens (Stage Five).

Figure 1: Missouri GME Advisory Committee Structure

Missouri Graduate Medical Education Advisory Committee

PURPOSE

The Missouri Graduate Medical Education Advisory Committee is established to advise the Missouri Department of Health and Senior Services (DHSS) on matters related to the development, support, and sustainability of Graduate Medical Education (GME) programs in the State of Missouri. The MO GMEAC will focus on ensuring that GME programs effectively address the physician workforce needs of Missouri, particularly in rural and underserved areas.

MISSION

To provide strategic guidance and recommendations to DHSS on GME policy and initiatives that enhance the quality, accessibility, and sustainability of healthcare services for all Missourians.

STANDING MEMBERS

Missouri Academy of Family Physicians
Missouri Area Health Education Centers
Missouri Department of Higher Education and Workforce Development
Missouri Department of Mental Health
Missouri Hospital Association
Missouri Primary Care Association
Missouri Rural Health Association/Missouri Association of Rural Health Clinics
MO HealthNet (Medicaid)

ROTATING MEMBERS

Two Representatives of Missouri Specialty Associations
Two Representatives of Missouri Medical Schools, with a preference for a representative from both allopathic and osteopathic schools
Two Missouri ACGME Sponsoring Institutions (i.e., Designated Institutional Official Representative)
One ACGME Accredited Primary Care Program operating less than four years (i.e., Program Directors from Family Medicine, Internal Medicine, OB/GYN, Psychiatry, Pediatrics, Med-Peds, and/or Surgery)

NORTH CAROLINA: USING WORKFORCE DATA AND FLEXIBLE FUNDING MODELS WITH TECHNICAL ASSISTANCE TO EXPAND RURAL TRAINING

The need

North Carolina has the second largest rural population in the nation, with approximately 30% of North Carolinians living in rural communities.¹⁴ As is the case in many other states, North Carolina’s rural communities lack a sufficient health care workforce. The state has seen a declining percentage of in-state medical school graduates and graduates who completed GME training in North Carolina practicing primary care and rural primary care in the state. Five years after graduating medical school in 2019, only 10% of graduates were in primary care residency programs or practicing primary care in the state, less than 1% practiced primary care in a rural county, and even fewer practiced rural general surgery or psychiatry.⁴ Retention in the state five years after completing residency decreased from 43% of those who completed residency between 2008 and 2011 to 37% of the 2017-2019 graduating cohort.¹⁵

These and other related workforce tracking data are available due to the long-standing data infrastructure of the North Carolina Health Professions Data System (HPDS) at The University of North Carolina (UNC) at Chapel Hill Cecil G. Sheps Center for Health Services Research (Sheps Center). The HPDS receives annual physician licensure files from the North Carolina Medical Board, and these data are cleaned and analyzed with funding from the North Carolina Area Health Education Centers Program. The state’s workforce data infrastructure has enabled workforce tracking and is used to help target workforce development initiatives.

These data combined with information on residency training sites derived from publicly available Accreditation Council for Graduate Medical Education (ACGME) data verified by programs are critical to understanding how well training capacity aligns with workforce needs. Of the 165 residency programs in the state:

- Sixty-nine residency programs train residents in one of the six defined high-need specialties (21 family medicine, 15 internal medicine, nine OB/GYN, five pediatrics, 10 psychiatry, nine general surgery).
- At baseline in 2024, there were 10 rural-based (three in internal medicine and seven in family medicine) residencies training 165 residents with more than 50% of their time in rural sites. Thirteen additional residencies had rural rotation sites, constituting a total of 66 rural rotation sites statewide.
- As of early 2026, there are 12 rural-based residencies training 189 residents with more than 50% of their time in rural sites and 15 additional programs with rural rotations statewide.
- Eight of the existing rural and underserved residencies have utilized federal funding — including the Rural Residency Planning and Development Program, the Teaching Health Center Planning and Development Program, and the Teaching Health Center Graduate Medical Education Program — for development and sustainability.

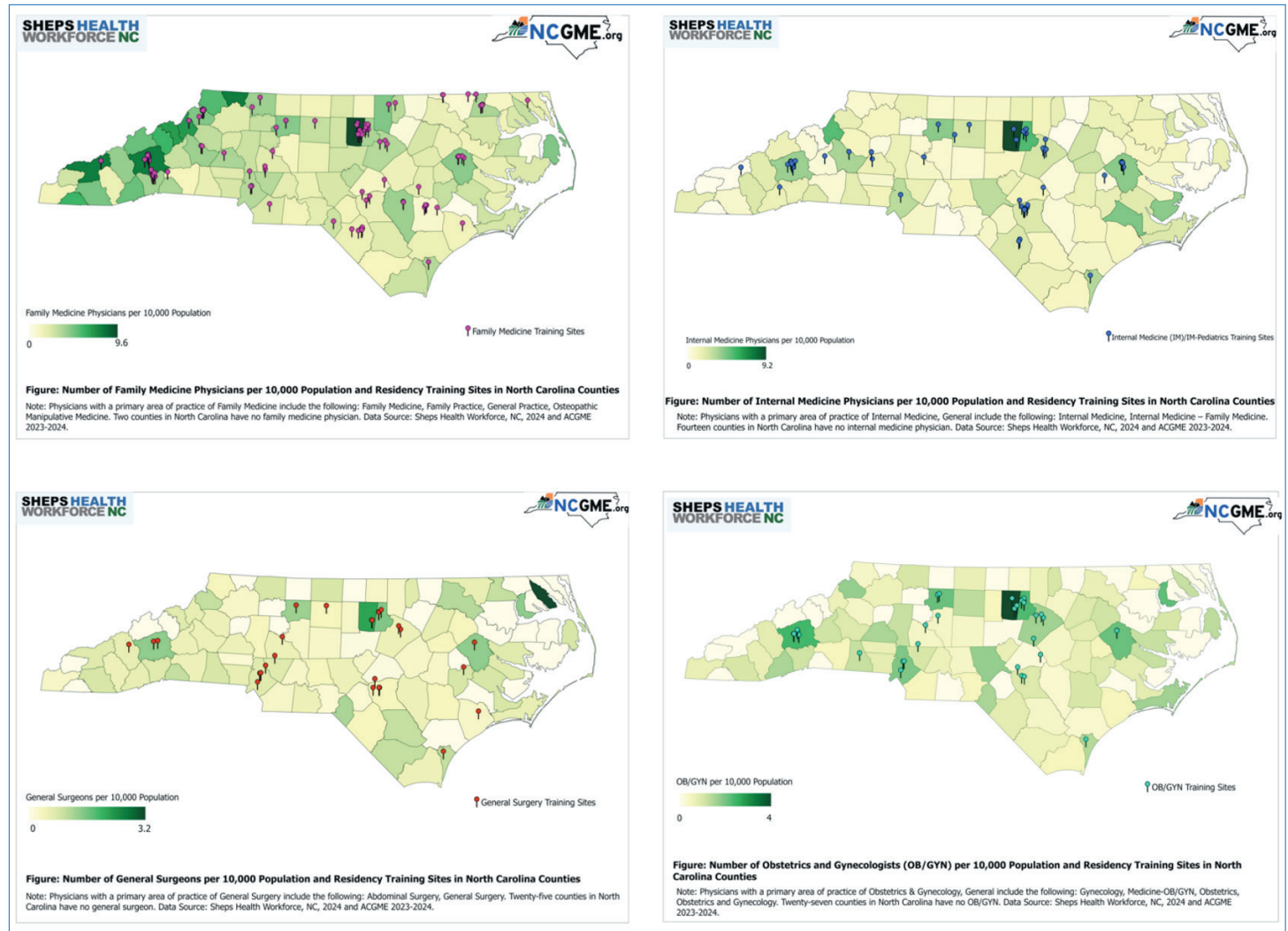
“A data-driven roadmap is essential for states seeking to grow and sustain their physician workforce. In North Carolina, decades of longitudinal data have informed a strategic approach that links identified workforce gaps, such as 25 counties without general surgeons, to targeted GME expansion, including plans for at least four rural surgery programs. This illustrates how intentional state strategy can translate evidence into durable workforce solutions.”
— Erin Fraher, PhD, MPP, Director of the Carolina Health Workforce Research Center, The University of North Carolina at Chapel Hill Cecil G. Sheps Center for Health Services Research

- Furthermore, there are 11 rural-based residencies in development across general surgery, psychiatry, obstetrics and gynecology, family medicine, pediatrics, and internal medicine, with more than 80 new resident positions projected.

The strategy

The state conducted an assessment of the existing physician training, workforce supply, and capacity of rural health facilities, shown in Figure 2 (Stage One of [A Roadmap for Building and Implementing a State Graduate Medical Education Strategy](#)).

Figure 2: The Distribution of the Training Sites and Physician Supply for Family Medicine, Internal Medicine, General Surgery, and Obstetrics and Gynecology in North Carolina



To address gaps identified in the assessment, the UNC System Office and the Sheps Center developed a grant program (shown in Figure 3) to launch, grow, sustain, and innovate with rural residency programs that place physicians where they are needed most (Stage Two, Stage Three).¹⁶

Figure 3: North Carolina Grant Types with Flexible Features (Lower Rural Training Time Requirements and the Ability for Residents to Train in Rural Census Tracts Within Metropolitan Counties)

Grant Type	Max Grant Period	Max Award Amount	Grant Renewal
Development	Up to 3 years	\$750,000	No
Expansion	Annual renewal, dependent on outcomes	\$150,000 per resident per year	Yes
Sustainability	Annual renewal, dependent on outcomes	\$150,000 per resident per year	Yes
Innovation	Up to 2 years	\$200,000	No

Funding

To build on the successful federal investments and bypass ongoing restrictions regarding Medicare financing, the North Carolina legislature appropriated recurring (\$8 million) and nonrecurring (\$23.5 million) dollars for the UNC System’s Rural Residency Medical Education and Training Fund.

Implementation

A technical assistance center (TAC) was funded to support grant recipients with program implementation as well as data tracking and outcome evaluation (Stage Four).⁸ Funding for the first cycle of grant applications was announced in April 2026. In 2027, the TAC will host a GME convening, evaluate and prioritize grant funding, offer comprehensive technical assistance, create learning networks, collect data, and track outcomes.

WISCONSIN: BUILDING SUSTAINABLE RURAL TRAINING THROUGH LONG-TERM PARTNERSHIPS AND COORDINATED TECHNICAL ASSISTANCE

The need

In the early 2000s, several rural training tracks closed in Wisconsin due to financial and operational challenges, resulting in gaps in primary care workforce development. In response to this and growing concerns regarding the size of its physician workforce, Wisconsin undertook statewide planning, including the creation of the Task Force on the Future Physician Workforce, led by the hospital association.¹⁷ The task force brought together hospitals, medical schools, physician organizations, and workforce leaders to assess physician supply, demand, and distribution across the state (Stage One of [A Roadmap for Building and Implementing a State Graduate Medical Education Strategy](#)).¹⁷ That assessment

“Physicians are retiring at a faster rate than we can replace them. And that creates longer waits for patients for clinic visits, for procedures, for specialty care. So we really need to continue to work hard on growing more physicians for Wisconsin. Fully leveraging efforts like Wisconsin ‘Grow Our Own’ GME grants will be essential to keeping up with the growing health care needs of an aging population.” — Ann Zenk, Senior Vice President of Workforce and Clinical Practice, Wisconsin Hospital Association

documented shortages in rural primary care and high-need specialties, particularly general surgery, and projected growth in physician demand amid limited workforce expansion (Stage Two).¹⁷

The task force’s recommendations emphasized expanding medical education capacity, strengthening physician retention, and establishing the infrastructure to support coordinated GME program growth and long-term sustainability, including accreditation support, financial stability, and strategic GME coordination.¹⁷

The strategy

The Task Force on the Future Physician Workforce’s recommendations led to the creation of several "grow your own" initiatives, with state funding for GME planning and development, as well as residency expansion.¹⁸ A technical assistance center was established through the Wisconsin Collaborative for Rural GME (WCRGME) to provide services and resources to new and existing programs (Stage Three, Stage Four).¹⁰

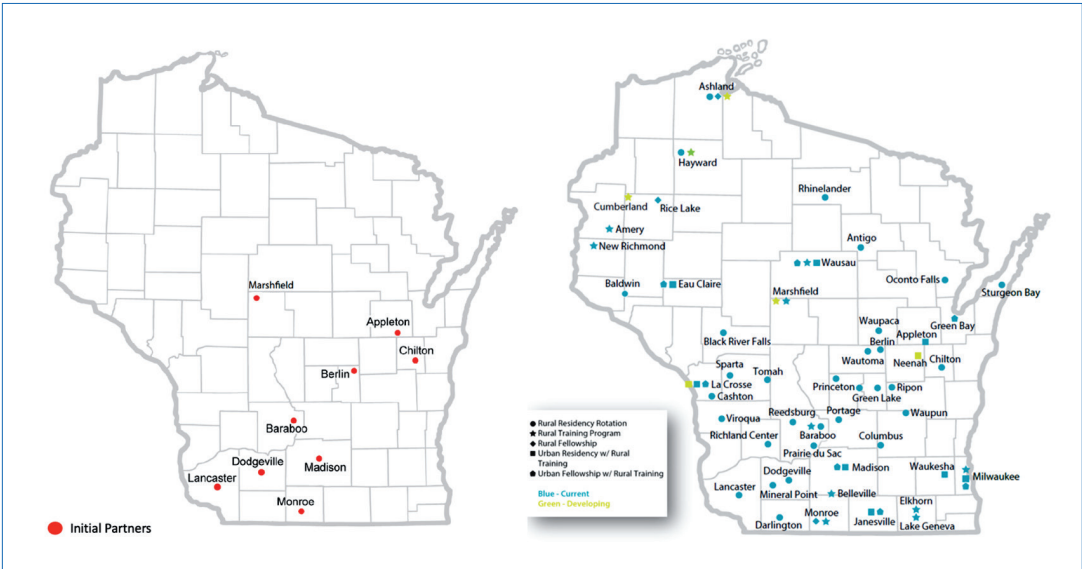
Funding

Legislative action in 2023 led to an increase in funding (to \$1 million per program for new program development and \$150,000 per resident for GME expansion), with consortium funding further supporting infrastructure in northern Wisconsin (Stage Five).^{19,20}

Implementation

Through this coordinated approach, statewide partners aligned priorities around primary care and other high-need specialties, tying accountability measures to rural training requirements and in-state retention goals (Stage Two, Stage Three). The initial WCRGME partner meeting in 2012 included 13 sites and organizations and has since grown to more than 60 residency programs and partners statewide. Figure 4 shows the expanded geographic distribution of Wisconsin’s GME training sites over time, reflecting intentional efforts to rebuild and sustain rural training capacity through coordinated partnerships and technical assistance.

Figure 4: Wisconsin GME Training Sites, 2012-2025



One notable component of the state’s strategy was the emphasis on flexibility in rural program design rather than adherence to Centers for Medicare and Medicaid Services (CMS) Rural Track Program (RTP) requirements. CMS RTPs require over 50% rural training for funding eligibility, a threshold that can be hard to achieve in some specialties, especially procedural specialties that require access to higher patient volume and complexity not present in rural community settings. The flexible approach enabled growth in high-need specialties (including surgery, OB/GYN, and psychiatry), with additional positions funded through state investments. Funding also supports rural rotation development and curriculum enhancement, which are complemented by WCRGME’s technical assistance in accreditation, financial planning, resident recruitment, and faculty development (Stage Three, Stage Four).

WCRGME monitors impact through annual surveys, while the Wisconsin Department of Health Services collects data on funded programs, including retention rates and graduate placement (Stage Five). These data systems ensure accountability and inform future strategy.

Since 2009, Wisconsin has added 30 new programs or tracks and over 300 residency positions, all with required rural training. More than 60% of graduates from expansion positions practice in-state, with the majority practicing in rural areas. Despite these gains, projected workforce needs continue to exceed current training capacity.²¹ Wisconsin workforce projections estimate a shortfall of more than 3,000 physicians by 2035, a number driven in part by an aging physician workforce (one in five practicing physicians is over age 65).²¹ Access indicators further reflect these pressures, showing that patients wait approximately 25% longer to obtain primary care appointments, on average, compared with prior years.²¹ Continued statewide coordination will be needed to continue to tackle these workforce challenges.

These state-level cases demonstrate that effective GME strategies are not defined by a single funding mechanism or program model, but by sustained coordination across planning, financing, implementation, and evaluation efforts. The [Roadmap for Building and Implementing a Comprehensive State Graduate Medical Education Strategy: Actionable Steps to Align Investments with Workforce Needs](#) offers states a flexible, iterative framework to align GME investments with workforce needs, adapt to local context, and complement federal GME policy.⁵ As new federal initiatives (such as the Rural Health Transformation Program) emphasize integrated, place-based training, these strategies illustrate how state-led GME planning and technical assistance can support broader rural health efforts and translate GME growth into sustained access gains.

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