HOD ACTION: Council on Medical Education Report 5 adopted as amended and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 5-A-13

Subject: Physician Workforce Shortage, Going Forward with Reforming GME Financing (Resolutions 317-A-12 and 329-A-12)

Presented by: Mahendr S. Kochar, MD, Chair

Referred to: Reference Committee C
(A. Patrice Burgess, MD, Chair)

Resolution 317-A-12, Physician Workforce Shortages, introduced by the Oklahoma Delegation and referred to the Board of Trustees, asked that our American Medical Association (AMA) work diligently with the Centers for Medicare and Medicaid Services (CMS) and the US Congress to create a supplemental private funding opportunity in addition to current funding sources to help develop additional residency training positions with private donations to cope with the critical shortage of primary care physicians in our country.

Resolution 329-A-12, Going Forward with Reforming GME Financing, introduced by the Mississippi Delegation and referred to the Board of Trustees, asked that our AMA:

1. Work with all available internal data and other available sources to craft a new national model for sustainable funding of graduate medical education (GME) programs, which includes not only the CMS funding, but also private funding sources as well, and

2. Urgently work to implement via legislation and other means this new model for funding GME programs in the United States.

This report provides an update on AMA efforts to improve GME funding at the federal, state, and regional levels.

BACKGROUND

Many experts agree that a predicted shortage of physicians in the coming years is a serious issue facing the nation. The Association of American Medical Colleges (AAMC) Center for Workforce Studies projects that the United States faces a shortage of physicians that may begin as early as 2015 and reach 130,000 across all specialties by 2025. Contributing to the physician shortage is continued growth of the US population; a projected 36% increase in the Medicare population; and an increased demand for physician services as 30 million Americans request more health care services due to the passage of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148). Furthermore, nearly one-third (250,000) of currently practicing physicians will reach age 60 and likely retire in the next 10 years.[1]

The number of medical school enrollments has risen in response to this anticipated shortfall of physicians. However, the training of resident physicians is heavily dependent upon funding through the Medicare system. Medicare has historically paid for its share of the costs of training through the highly sophisticated health services provided by teaching hospitals, but the 1997 Balanced Budget

Act capped the number of Medicare-funded GME positions at 1996 levels for almost all teaching hospitals. As a result, growth in the number of core GME programs, a prerequisite for medical licensure, has been minimal.[2]

While debate continues about how best to fund and structure GME, many agree that proposals such as the Medicare Payment Advisory Commission (MedPAC) proposal to cut GME funding as much as 50% would impact the entire nation.[3] Residents and fellows continue learning while providing direct patient care in hospitals and clinics under the direct supervision of a teaching physician. They render care to medically underserved, indigent, and elderly patients who otherwise might not have access to health care services.[4] In 2011, the Accreditation Council for Graduate Medical Education conducted a survey of GME programs and reported that a 50% reduction in Medicare GME funding would result in the closing of 2,551 (28.7%) residency and fellowship programs nationwide and the loss of 33,023 (29.2%) GME positions.[5]

The ACA authorized redistribution of some unused GME residency slots and has provided a few new residency positions in primary care and general surgery, but these changes will not be enough to build an appropriately sized and fully trained medical workforce. Given the long pipeline for physician training (7 years post-college at a minimum), combined with the years required to build and accredit new residency programs, expansion of GME should be approached with some urgency.

AMA ADVOCACY REGARDING GME

The AMA continues to collaborate with the AAMC and other key stakeholders to advocate for GME funding and alert Congress that cuts to GME funding would jeopardize the ability of medical schools and teaching hospitals to train physicians, as well as limit critical services to patients. The following is a summary of important federal legislative activity in the 112th Congress and AMA advocacy efforts on GME.

- On April 20, 2011, the AMA supported H.R. 1852, the "Children's Hospital GME Support Reauthorization Act of 2011," which would reauthorize federal funding to support GME positions for freestanding children's hospitals.

- On October 3, 2011, the AMA issued strong support for S. 1627, the "Resident Physician Shortage Reduction Act of 2011," a federal bill introduced by Senators Bill Nelson (D-FL), Harry Reid (D-NV), and Charles Schumer (D-NY) which would expand the number of Medicare-supported GME training positions by 15 percent (approximately 15,000 additional positions) over five years.

- On October 3, 2011, the AMA joined the AAMC and 38 other physician, hospital, and educational associations urging the Congressional Committee on Deficit Reduction to protect Medicare GME funding from cuts.

- On October 15, 2012, the AMA sent a letter to Representative Crowley (D-NY) in support of H.R. 6562, the "Resident Physician Shortage Reduction Act of 2012," which would expand the number of Medicare-supported GME positions by 15 percent (an additional 15,000 positions) over five years.

- The Josiah Macy Jr. Foundation designed a series of two conferences to develop recommendations regarding the future of GME in the United States. The AMA participated in the first conference held on October 24, 2010. The first published report, "Ensuring an

Effective Physician Workforce for America: Recommendations for an Accountable GME System," embraces an all-payer model for GME funding.[6] Following the second conference, the Foundation published a second report, "Ensuring an Effective Physician Workforce for the United States: Recommendations for Reforming GME to Meet the Needs of the Public," which focused on the content, structure, and format of the GME system.[7]

- On December 19, 2012, the AMA testified before the Institute of Medicine (IOM) Committee on the Governance and Financing of Graduate Medical Education (the AMA's written testimony is available at: *www.ama-assn.org/resources/doc/washington/graduate-medical-education-testimony-19dec2012.pdf*). By the Spring of 2014, the IOM committee will: (1) assess current regulation, financing, content, governance, and organization of US GME; and (2) recommend how to modify GME to produce a physician workforce for a 21st century US health care system that provides high quality preventive, acute, and chronic care, and meets the needs of an aging and more diverse population.[8]

- Starting in December 2012, the AMA launched a new grassroots campaign to raise awareness in Congress of the need to preserve funding for residency training in the federal budget. Physicians and medical students were called on to urge their members of Congress to support GME funding by sending an email through the AMA Physicians Grassroots Network (*www.SaveGME.org*). On February 11, 2013, medical students from across the nation talked with Members of Congress on this topic. Physicians attending the 2013 National Advocacy Conference also raised the need to protect GME funding during conversations with their representatives and senators.

- On March 7, 2013, AMA provided background material to the Government Accountability Office (GAO) for their study on physician and health care workforce supply and demand and how provisions in the ACA may affect estimates of future needs. The GAO is expecting to issue their findings later this year.

The AMA continues to pursue its GME advocacy campaign with the 113th Congress. On January 29, 2013, the AMA supported H.R. 297, the "Children's Hospital GME Support Reauthorization Act of 2013," which would reauthorize federal funding to support GME for free-standing children's hospitals. On March 19, the AMA also supported S.577 and H.R. 1180, the "Resident Physician Shortage Reduction Act," which would expand the number of GME slots by 15 percent (an additional 15,000 GME slots).

The AMA has also been closely monitoring the activities of the following organizations that are studying GME financing:

- The Council on Graduate Medical Education (COGME), the entity mandated by Congress to study and advise the federal government about the nation's physician workforce, convened twice in 2012 to prepare its upcoming 21st report on "Restructuring Graduate Medical Education." COGME has recommended that funded GME positions be increased by a minimum of 15% to directly support innovative training models that address community needs and reflect emerging, evolving, and contemporary models of health care delivery, e.g., the patient-centered medical home. COGME has also recommended the adoption of an all-payer GME system.[9]

- MedPAC has been reviewing ways to improve GME through Medicare's teaching payments with the goal of creating a payment system that fosters greater accountability for

> Medicare's GME dollars and rewards education and training that will improve the health care delivery system. MedPAC's proposed performance-based funding system does not address the supply, mix, and geographic distribution of physicians.[10]

While several federal bills introduced during the 112th Congress would increase GME funding to address physician shortages, other federal bills tied GME payments to an accountability and transparency program. With an accountability and transparency program, teaching hospitals that do not meet performance standards would face reduced Indirect Medical Education (IME) payments. As federal policymakers continue to discuss the budget and reducing the federal deficit in recent years, funding for federally funded programs including GME are under scrutiny. In December 2010, the Simpson-Bowles Commission put forth a plan to reduce Medicare funding for residency training programs by $60 billion over a 10-year period. President Obama recommended a cut of $11 billion over 10 years in his FY 2014 budget plan. Moreover, federal funding for GME is currently being reduced by the 2 percent sequestration cut that went into effect on April 1.

As the AMA continues with its mission at the federal level to ensure that adequate GME opportunities exist, state and local-based strategies to justify and support GME funding are also becoming more critical. At a November 2010 summit, the AMA, in collaboration with leaders from GME programs, state medical societies, and national medical organizations discussed state-based GME funding options. The summit's goal was to develop successful strategies that state and regional stakeholders could embrace for political action to expand GME funding to meet state and regional medical workforce needs. A brochure, which was published following the summit, contains recommendations and policies supported by the AMA (Appendix A).

AMA EFFORTS IN EDUCATION ACROSS THE CONTINUUM

The AMA has set forth a multi-year strategy, defined during a period in which the state and future of health care appear particularly unsettled.[11] The AMA outlined a long-range strategic plan that focuses on three core areas that include improving patients' health outcomes while reducing health care costs, accelerating change in medical education to align physician training and education with the future needs of patients and the health care system, and enhancing professional satisfaction and practice sustainability by helping physicians navigate delivery and payment models.

The AMA plans to accelerate change in undergraduate medical education in part to align with the changes that are occurring with the restructuring of the GME accreditation system. In January 2013, the AMA released a request for proposals to US medical schools to submit proposals for funding that embrace bold change in medical education programs to better meet the needs of an evolving health care system. As part of the RFP process, schools are encouraged to consider innovations that support new, flexible, and outcomes-based education across the continuum. In addition, the AMA will convene a learning collaborative of participating medical schools and additional partners to evaluate and promote adoption of successful innovations.

AMA POLICY

AMA Policies H-305.929, "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs," H-310.917, "Securing Funding for Graduate Medical Education," D-305.967, "The Preservation, Stability, and Expansion of Full Funding for Graduate Medical Education," D-305.958, "Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy," and D-305.973, "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs" (Appendix B) are relevant to this discussion.

AMA policy supports maintaining adequate and stable Medicare and Medicaid GME funding levels, advocating for the contribution by all payers for health care to fund the cost of GME (e.g. the federal government, states, and private payers), actively exploring additional sources of GME funding and their potential impact on the quality of residency training and patient care, and making new funding available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties.

Policy H-305.929 (4) states that diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions.

Policy D-305.967 (11) states that the AMA recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; and directs the AMA to immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce, and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda.

DISCUSSION

Medicare is still the single largest funding source for GME, and CMS funding helps offset some of the costs associated with educating residents, caring for patients in teaching hospitals who often require more intense and complex care, and other special missions of teaching hospitals. Medicare pays approximately $9.5 billion annually for direct and indirect costs of GME programs throughout the country, but this funding does not come close to the cost of maintaining teaching programs (approximately $27 billion per year).[12] Sponsoring institutions have found it difficult to maintain their net income, which has depended in part on revenue generated by resident service and CMS funding.[13, 14]

It will be important now more than ever to continue pressing policymakers to protect or increase GME funding. Such support is essential to ensuring teaching hospitals' ability to provide patient care as well as preventing a worsening of the physician shortages that have already been identified by 33 states and 22 physician specialty organizations.[15] In this regard, the AMA will continue to collaborate with the AAMC and other key stakeholders to advocate for GME funding.

AMA has long-standing policy to advocate for the contribution by all payers for health care (including the federal government, states, and private payers) to fund both the direct and indirect costs of GME. Pulling in other payers for GME could increase the number of training positions without placing additional financial burden on Medicare. An all-payer system could also be an important contribution to deficit reduction by spreading the responsibility for funding GME to all who benefit from it instead of the federal government bearing a disproportionate share of the cost, as it currently does. However, private insurers have consistently opposed mandates that would require them to pay a portion of GME expenses.[16] Given the number of stakeholders involved in GME, it is of critical importance that the AMA continues to work with all stakeholders to explore and agree upon proposals for GME governance and financing. Proposed changes in GME should be carefully considered and crafted and agreed upon to avoid exacerbating projected shortages of physicians across all specialties including primary care. As the AMA continues to work with GME

stakeholders on assessing a secure, rational, and fiscally sound GME funding model, AMA policy that supports new sources of funding for GME including private payers should also be considered.

In the long run, reimbursement reform may begin to reward accountable health care organizations (ACOs) that have the ability to manage complex chronic diseases efficiently and prevent unnecessary hospitalizations.[17] Broad participation in this model, however, may be constrained by the loss of payments for advanced clinical care, care to the underserved, and medical education payments associated with hospital stays.[17] The Teaching Health Center Graduate Medical Education (THCGME) program, created and funded under the ACA, offers opportunities to explore alternative solutions to GME funding, such as institutional indirect educational costs, variations in trainee-related productivity gains, and the program cost of GME innovations in non-hospital settings and in primary care.[18]

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education envisions a health care system based on an adequate number of highly trained physicians who can work efficiently and effectively to provide high-quality care to all US citizens. The AMA is working with the AAMC and other stakeholders to advocate for the expansion of the graduate medical education (GME) workforce.

Therefore, the Council on Medical Education recommends that the following statements be adopted in lieu of Resolutions 317-A-12 and 329-A-12 and the remainder of this report be filed:

1. That our AMA reaffirm Policies H-305.929, "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs," H-310.917, "Securing Funding for Graduate Medical Education," D-305.967, "The Preservation, Stability, and Expansion of Full Funding for Graduate Medical Education," D-305.958, "Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy," and D-305.973, "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs." which support adequate and stable funding as well as new sources of funding for graduate medical education from all payers for health care including the federal government, the states, and private payers. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-305.929 (4), "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs," which states that diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy D-305.967 (11), "The Preservation, Stability, and Expansion of Full Funding for Graduate Medical Education," to recognize that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; and to direct AMA to immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce, and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda. (Reaffirm HOD Policy)

4. That our AMA work with the Association of American Medical Colleges and other key stakeholders to continue to examine alternative models of funding for graduate medical education, with a report back at the 2014 Annual Meeting. (Directive to Take Action)

Fiscal Note: No significant fiscal impact

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Appendix A

AMA Center for Transforming Medical Education and
AMA Advocacy Resource Center

Critical condition: The call to increase graduate medical education funding

AMA AMERICAN MEDICAL ASSOCIATION

Strategies and solutions

To ensure an adequate physician workforce and better access to care, proper GME funding is a must.

Many authorities agree that by 2025 the United States will face a shortage of physicians to meet the needs of a growing and aging U.S. population. Since 2000 at least 26 states and 17 medical specialties have reported physician workforce shortages, and an additional five states and five medical specialties predict coming shortages.

While new U.S. allopathic and osteopathic medical schools are opening and many medical schools are expanding their enrollments to meet the need for more physicians, **graduate medical education (GME) core training programs are experiencing minimum growth due to limited funding.** This imbalance is exacerbating the shortage of physicians.

Background: From Flexner to the Patient Protection and Affordable Care Act

After the Flexner Report was published in 1910, a single model of medical education became the norm in the United States. A number of substandard medical schools were closed, which caused the number of physicians per capita to decrease in the first half of the 20th century. This trend reversed in the second half of the century as the number of medical schools expanded and as Medicare became law in 1965. Growth continued until the 1997 Balanced Budget Act capped the number of Medicare-funded GME positions.

With the number of medical school graduates increasing and competition for entry level residency slots intensifying, the cap has made it difficult for institutions to expand training programs. The 2010 Patient Protection and Affordable Care Act (PPACA) authorized redistribution of unused GME residency slots and allowed greater flexibility for GME programs to count training in outpatient settings. Although other minor provisions in the PPACA may increase the number of resident physicians in primary care and general surgery, these changes will not be enough to build a fully trained medical workforce.

Completion of an accredited core residency program is required for certification by a member board of the American Board of Medical Specialties, and board certification is becoming a standard for physicians to practice in hospitals or to be included in insurance plans. Given the long pipeline for physician training (at least seven years post-college), combined with the years required to build and accredit new residency programs, expanding GME now will not have a major impact on the doctor-to-population ratios for several decades.

Objectives: Better data, flexibility and innovation

At a November 2010 summit, the American Medical Association (AMA) Center for Transforming Medical Education and the AMA Advocacy Resource Center, in collaboration with leaders from GME programs, state medical societies and national medical organizations, discussed state-based GME funding options. The summit's goal was to develop successful strategies that state and regional stakeholders could embrace for political action to expand GME funding to meet state and regional medical workforce needs.

The consensus process was guided by four main objectives:

1. **State-level physician data is essential to show the need to expand GME in underserved areas throughout the United States.**
2. **Additional sources of GME funding must be identified, and current sources must be preserved.**
3. **Innovative methods to distribute GME funds in states and regions must be developed.**
4. **Flexibility in GME training methods, venues and sites will be required to meet future patient needs.**

Recommendations

Collect meaningful data that shows the need to expand GME to meet state and regional workforce needs.

Health workforce planning should be a shared federal-state responsibility. Each state should determine the medical workforce needs of its communities while the federal role should focus on developing data collection guidelines, and on providing guidance through national data collection and analysis. Federal grants can provide incentives to states looking to expand their training programs. These investments can provide an important platform for expanding the primary care workforce and creating more opportunities to prepare physicians to practice in community-based settings. States also play a significant role in supporting education and training, licensure and regulation of practitioners, state and local public health, scholarships and loan repayment programs, tracking of employment and regulation of practice.

Identify current and potential sources of expanded funding for GME.

All payers for health care—including the federal government, the states and private payers—benefit from GME. Therefore, the AMA advocates that all payers, including private insurance companies, should directly contribute to its funding. In addition, current sources of funding must be preserved. These include Medicare, which provides $9.5 billion in funding; Medicaid, through state appropriations and matching federal payments (nearly $2 billion); and the Department of Veterans Affairs (VA), which provides $1 billion. In addition to sustaining current GME funding and requiring contributions from all payers for health care, new funding streams (such as trusts created by the conversion of not-for-profit entities) could be developed to increase residency positions. Preferably, these new programs would be located in or adjacent to physician shortage/underserved areas and in undersupplied specialties and subspecialties.

Identify successful methods to distribute GME funds to meet state and regional needs.

Several states and the VA are using innovative GME financing approaches that take into account regional or national physician workforce needs in allocating GME funding. Successful state models are also moving toward new and renewable funding streams. Some models include combining funds from Medicare, Medicaid, and private insurers to collectively support GME growth in needed geographic areas and/or specialties.

Support funding for training in non-hospital sites.

The current funding mechanisms for GME are largely tied to hospital settings, whereas most medical care occurs in ambulatory settings. The demands on resident physicians to provide hospital services leaves little room for developing innovative GME programs featuring interdisciplinary care across all settings, including physicians' offices, hospital outpatient and inpatient services, nursing homes and community-based programs. If physicians are only educated in practice models defined by inpatient care, the future physician workforce will lack adequate experiences to meet the nation's needs and expectations. Centers for Medicare & Medicaid Services rules must create flexibility for funding GME in community-based sites and settings.

Strategies supported by the AMA

Strategies for expanding GME to support community workforce needs

- Expand GME as needed geographically to address the future workforce needs of the nation
- Encourage training programs to better prepare physicians to care for a diverse patient population with chronic diseases
- Ensure adequate GME opportunities for U.S. medical graduates to complete core training programs
- Broaden the definition of "training venues" to include non-traditional training sites (e.g., teaching health centers) to deliver patient-centered, coordinated, inter-professional, and interdisciplinary care
- Ensure that all resident physicians who enter GME programs have access to completing their training in an accredited core residency with appropriate supervision by experienced faculty

Strategies state/regional stakeholders can embrace for political action

- Collect state-level physician data to support the need to expand GME in underserved areas
- Support incentives for students to choose specialties/careers to meet societal needs
- Explore alternative sources for GME funding (e.g., private payers)

Solutions supported by the AMA

- Ensure adequate GME opportunities for qualified applicants, including international medical graduates
- Ensure a well-trained, competent medical workforce entering practice
- Encourage appropriate medical workforce expansion to correct shortages by specialty and geography
- Seek all-payer funding for core residency programs leading to initial board certification
- Align federal and state incentives through:
  - All-payer GME system (federal or state mandates)
  - GME funds to meet broader community needs
  - Reduced disparities in medical access and quality
  - Support of GME in innovative health care systems (e.g., patient-centered medical homes and accountable care organizations)

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Visit the following website for more information:

www.ama-assn.org/go/gmenews

AMA AMERICAN MEDICAL ASSOCIATION

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Appendix B

AMA Policies on GME Financing and Medical Workforce

H-305.929 Proposed Revisions to AMA Policy on the Financing of Medical Education Programs

It is AMA policy that:

(1) Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public.

(2) Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved.

(3) Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding.

(4) Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions.

(5) All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding.

(6) Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage.

(7) Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training.

(8) Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs.

(9) New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties. (CME Rep. 7, A-05; Reaffirmation I-06; Reaffirmed: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmed: CME Rep. 15, A-10; Reaffirmation A-11)

H-310.917 Securing Funding for Graduate Medical Education

Our American Medical Association will: (1) continue to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities); and (2) continue to advocate for graduate medical education funding that reflects the physician workforce needs of the nation. (CME Rep. 3, I-09; Modified: CME Rep. 15, A-10; Reaffirmed in lieu of Res. 324, A-12)

D-305.967 The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).

2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.

3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).

4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.

5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.

6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).

7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.

8. Our AMA will vigorously advocate for the contribution by all payers for health care, (including the federal government, the states and private payers), to funding both the direct and indirect costs of GME.

9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.

10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.

11. Our AMA: (A) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (B) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (C) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs. (Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmation A-11; Appended: Res. 910, I-11; Reaffirmed in lieu of Res. 303, A-12; Reaffirmed in lieu of Res. 324, A-12)

D-305.958 Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy

1. Our AMA will ensure that actions to bolster the physician workforce must be part of any comprehensive federal health care reform.

2. Our AMA will work with the Centers for Medicare and Medicaid Services to explore ways to increase graduate medical education slots to accommodate the need for more physicians in the US.

3. Our AMA will work actively and in collaboration with the Association of American Medical Colleges and other interested stakeholders to rescind funding caps for GME imposed by the Balanced Budget Act of 1997.

4. Our AMA will actively advocate for expanded funding for entry and continued training positions in specialties and geographic regions with documented medical workforce shortages.

5. Our AMA will lobby Congress to find ways to increase graduate medical education funding to accommodate the projected need for more physicians.

6. Our AMA will work with key organizations, such as the US Health Resources and Services Administration, the Robert Graham Center, and the Cecil G. Sheps Center for Health Services Research, to: (A) support development of reports on the economic multiplier effect of each residency slot by geographic region and specialty; and (B) investigate the impact of GME funding on each state and its impact on that state's health care workforce and health outcomes. (Sub. Res. 314, A-09; Appended: Res. 316, A-12)

D-305.973 Proposed Revisions to AMA Policy on the Financing of Medical Education Programs

Our AMA will work with:

(1) the federal government, including the Centers for Medicare and Medicaid Services, and the states, along with other interested parties, to bring about the following outcomes: (a) ensure adequate Medicaid and Medicare funding for graduate medical education; (b) ensure adequate Disproportionate Share Hospital funding; (c) make the Medicare direct medical education per-resident cost figure more equitable across teaching hospitals while assuring adequate funding of all residency positions; (d) revise the Medicare and Medicaid funding formulas for graduate medical education to recognize the resources utilized for training in non-hospital settings; (e) stabilize funding for pediatric residency training in children's hospitals; (f) explore the possibility of extending

full direct medical education per-resident payment beyond the time of first board eligibility for specialties/subspecialties in shortage/defined need; (g) identify funding sources to increase the number of graduate medical education positions, especially in or adjacent to physician shortage/underserved areas and in undersupplied specialties; and (h) act on existing policy by seeking federal legislation requiring all health insurers to support graduate medical education through an all-payer trust fund created for this purpose; and

(2) other interested parties to ensure adequate funding to support medical school educational programs, including creating mechanisms to fund additional medical school positions. (CME Rep. 7, A-05; Reaffirmation I-06; Reaffirmation I-07)

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