

HOD ACTION: Recommendations 3 and 5 in Council on Medical Education Report 3 adopted as amended, Recommendation 1, 2, 4, and 6 adopted, Additional Recommendation 7 adopted, and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3, November 2020

Subject: Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure

Presented by: Liana Puscas, MD, MHS, Chair

Referred to: Reference Committee C
(, MD, Chair)

1 INTRODUCTION

2
3 Policy H-310.943, (2), “Closing of Residency Programs,” directs our AMA to:

4
5 Study and provide recommendations on how the process of assisting displaced residents and
6 fellows could be improved in the case of training hospital or training program closure,
7 including:

8
9 A. The current processes by which a displaced resident or fellow may seek and secure an
10 alternative training position; and

11
12 B. How the Centers for Medicare and Medicaid Services (CMS) and other additional or
13 supplemental graduate medical education (GME) funding is re-distributed, including but not
14 limited to: (1) the direct or indirect classification of residents and fellows as financial assets
15 and the implications thereof; (2) the transfer of training positions between institutions and the
16 subsequent impact on resident and fellow funding lines in the event of closure; (3) the transfer
17 of full versus partial funding for new training positions; and (4) the transfer of funding for
18 displaced residents and fellows who switch specialties.

19
20 Strong testimony in support of this policy’s underlying resolution was heard during the 2019
21 Interim Meeting, due to the fall 2019 closure of Hahnemann University Hospital (HUH) in
22 Philadelphia and the urgent need for AMA action to aid the individuals affected and to develop
23 policies to ensure adequate protections in the future. Concerns were expressed related to the
24 graduate medical education (GME) funding for residents inadvertently displaced, as might occur
25 with a natural disaster (e.g., Hurricane Katrina), versus those who are removed from a residency
26 program due to issues with clinical performance and/or professionalism. This report addresses
27 displacement as a result of program closure.

28
29 BACKGROUND

30
31 The events preceding and following the abrupt closure of HUH have been well documented in the
32 academic medicine press as well as in the popular press. What follows is a brief summary.

1
2 HUH, a large, academic safety-net hospital in Philadelphia, had struggled financially for years. It
3 had been purchased twice by for-profit investors, first in 1998 by Tenet Healthcare Corporation and
4 then in 2018 by American Academic Health System (AAHS). In 2019, AAHS concluded that HUH
5 was no longer financially viable; subsequently, in late June 2019, HUH announced its closure and
6 then filed for Chapter 11 bankruptcy in July. AAHS announced on July 24 that it was withdrawing
7 from accreditation its 25 medical residency/fellowship programs. This left more than 550 resident
8 and fellow physicians (referred to as residents in this report), including 140 new residents who had
9 not even started training at the time of the announcement, without a program accredited by the
10 Accreditation Council for Graduate Medical Education (ACGME) in which to continue their
11 medical education.^{1,2,3,4}

12
13 Withdrawal from accreditation by an entire program “displaces” the residents in the program. At
14 that point, the resident is allowed to pursue training in another program, with allocated funding
15 from the Centers for Medicare & Medicaid Services (CMS).⁴ The ACGME has policy, developed
16 after the training disruption of Hurricane Katrina in 2005, to assist residents and fellows with
17 temporary and permanent transfers to other programs.³ This assistance, and the call to action by the
18 ACGME asking for programs to post availability of positions, enabled all residents displaced by
19 the closure of HUH to secure new positions within 43 days, half of them within a 60-mile radius of
20 Philadelphia.^{1,2} Interestingly, the same process came into play only a few months later with the
21 closure of Ohio Valley Medical Center (OVMC) in West Virginia, also for financial reasons.
22 OVMC operated only two ACGME-accredited programs, and therefore substantially fewer
23 residents were displaced.

24 25 “ORPHANED” RESIDENT PLACEMENT PROCESS

26 27 *ACGME*

28
29 On June 28, 2019, the ACGME invoked its Extraordinary Circumstances Policy in response to the
30 announcement of HUH’s closing. The ACGME created a database on its website, accessible to
31 GME leaders and residents at HUH, for programs to post potential training position openings for
32 displaced HUH residents. This database was updated daily, with 1,530 positions offered from 90
33 sponsoring institutions in 39 states.³ Program directors and designated institution officials (DIOs)
34 submitted requests to ACGME review committees for complement increases to accept some of the
35 residents. In late July, the ACGME announced that it was accepting applications for new training
36 programs, and eventually accredited 31 new programs in Pennsylvania.² Residents started
37 interviewing at other institutions that had offered potential positions, and while GME Resident
38 Displacement Agreements were developed by HUH, CMS funding was in question until the
39 programs were officially unaccredited and residents released. Even then (July 29 for one group of
40 residents, August 6 for another), the CMS funding was complicated by both CMS regulations and
41 the stated intent of AAHS to sell the residency slots as an asset.²

42 43 *CMS*

44
45 Prior to the passage of the Affordable Care Act (ACA), if a teaching hospital closed, its direct
46 GME and indirect resident cap slots would be “lost,” because those slots were associated with the
47 specific hospital’s terminated Medicare provider agreement. However, Section 5506 of the ACA
48 addressed this situation by establishing a process that would redistribute slots from closing teaching
49 hospitals to hospitals that met certain criteria, with priority given to hospitals located in the same
50 Core Based Statistical Area (CBSA) or in a contiguous CBSA as the closing hospital. As a result,
51 Section 5506 applies to teaching hospitals that closed on or after March 23, 2008.

1
2 Despite Section 5506, residents and receiving hospitals have still found it difficult to receive cap
3 slot adjustments, and the associated funding, due to a CMS rule that requires residents to be
4 “physically present” at a closing hospital to be considered displaced. “Physically present” is
5 defined as training at a hospital on the day prior to, or the day of, hospital or program closure. This
6 definition creates problems for: 1) residents who leave the program after the closure is publicly
7 announced to start training at another hospital but before the actual closure, 2) residents assigned to
8 and training at planned rotations at other hospitals who cannot return to their rotation at the closing
9 hospital or program, and 3) residents who matched into GME programs at the closing hospital or
10 program but have not yet started training at that hospital or program. As such, CMS regulations
11 regarding the funding of displaced residents are perceived as burdensome and inflexible by
12 residents, program directors, and DIOs. Moreover, CMS regulations added uncertainty about the
13 financial risk that institutions that intended to accept transferring residents could potentially incur.²
14

15 Additionally, CMS regulations assert that it is at the discretion of the closing hospital or program to
16 allocate whatever amount of full-time equivalent (FTE) cap it deems fit. This has caused
17 uncertainty for residents and receiving hospitals regarding the amount of funding that will travel
18 with the transferring resident. For example, in the case of HUH, residents did not receive a 1.0 FTE
19 and instead were given about 80 percent of their allotted funding, per an arrangement with Thomas
20 Jefferson University Hospital and the University of Pennsylvania.⁴
21

22 Finally, there have been discrepancies in the past regarding if residency slots are, or are not,
23 “assets” of the closing hospital or program. When HUH tried to sell its 550 residency slots as
24 “assets” during bankruptcy proceedings, the presiding judge initially allowed bidding on the slots.
25 As a result, a coalition of local hospitals bid \$55 million on the slots with the goal of keeping them
26 in the Philadelphia region, while a health care firm in California bid \$60 million for the valuable
27 chance to increase the number of funded physicians in its hospitals. However, CMS objected to the
28 judge’s ruling and asserted that CMS has sole discretion concerning the allocation of Medicare-
29 funded slots. CMS argued that the auction would set a dangerous precedent, in that struggling
30 hospitals with training positions could be purchased by investors, leaving certain hospitals severely
31 understaffed. As a result, the auction did not go forward.^{5,6}
32

33 *Further Complications: Visa Regulations, Medical Liability Coverage, and Economic Impacts* 34

35 Among the residents training in HUH programs were 59 individuals on J-1 visas who were
36 required to find a position with another GME program within 30 days of the hospital closing or
37 face deportation from the U.S. The AMA wrote a letter to the U.S. Department of State (DoS)
38 urging the DoS to work with U.S. Citizenship and Immigration Services and the Educational
39 Commission for Foreign Medical Graduates (ECFMG) to waive the 30-day grace period
40 requirement and provide needed support for these individuals to find an appropriate alternative
41 GME program. The DoS agreed to review, on a case-by-case basis, anyone who did not have a
42 position lined up within the 30-day period. The ECFMG was instrumental in assisting these
43 residents as they moved to new programs, including meeting with them in person, providing
44 financial assistance, and waiving ECFMG fees. All residents with J-1 visas found positions.^{3,7,8}
45

46 After HUH residents had found new positions, it was revealed in December that they would lose
47 long-tail medical liability coverage for claims made after January 10, 2020—this, despite an
48 ACGME institutional requirement that sponsoring institutions must have malpractice insurance
49 covering any claims made while the resident is training or any future claims stemming from the
50 resident’s training period. AAHS had intended to purchase the coverage through the sale of the
51 residency slots, which was tied up in court, and ultimately did not go through. In February, AAHS

1 agreed to pay \$6.2 million to purchase medical liability insurance for the residents and other
2 medical professionals who had worked at HUH during its ownership.⁹ In the meantime, the AMA
3 underwrote the costs of a legal team assisting residents in their fight to obtain medical liability
4 coverage from HUH. The AMA also joined the Philadelphia County Medical Society (PCMS),
5 Pennsylvania Medical Society (PAMED), ECFMG, ACGME, and Association of American
6 Medical Colleges (AAMC) in urging the institutions that accepted HUH residents to help purchase
7 tail coverage, especially important in the state of Pennsylvania, which requires, as do other states,
8 that all physicians have tail coverage from previous employers.¹⁰
9

10 The extensive disruption to the lives of residents and their families cannot be discounted. Besides
11 suddenly potentially uprooting families to move to locations that may be distant, residents stood to
12 forfeit large deposits on rental housing, while having to make new deposits in the new location.³
13 The AMA committed \$50,000 to assist the residents affected, and the AMA Foundation committed
14 another \$20,000 to help. The American Osteopathic Association, American Board of Medical
15 Specialties, AAMC, Council of Medical Specialty Societies, National Board of Medical
16 Examiners, PAMED, PCMS, and many other organizations financially committed funds to support
17 residents during this difficult transition, with the goal of raising \$150,000 all told for the
18 Hahnemann University Displaced Resident Fund. The ECFMG created a fund for residents who
19 had J-1 visas.¹¹
20

21 CMS CHANGES PROPOSED

22

23 As mentioned above, CMS has regulations defining a displaced resident as one who is “physically
24 present” at a hospital on the day prior to, or the day of, hospital or program closure. This
25 significantly hampers the ability of residents to seek and find new positions should a program or
26 institution suddenly close and excludes residents who have matched to the closing program but
27 have not started their residencies. On July 25, 2019, the AMA sent a letter to CMS requesting that
28 CMS: 1) address the physical presence requirement; 2) resolve the question of transitional residents
29 who had matched to HUH programs but were not currently employed by HUH or in a program at
30 the time of closure, and who therefore did not have federal funding that transferred with them, and
31 3) provide full funding for residents.¹²
32

33 While CMS was not able to address these issues in the case of HUH residents, CMS has proposed
34 rule changes that will link Medicare temporary funding for displaced residents to the day program
35 or hospital closures are publicly announced (for example, via a press release or a formal notice to
36 the ACGME). This provides greater flexibility for residents to transfer while the hospital
37 operations or residency programs are winding down, rather than waiting until the last day of
38 hospital or program operation. In addition, CMS has proposed to allow funding to be transferred
39 temporarily for residents who are not physically at the closing hospital or closing program, but had
40 intended to train at (or return to training at, in the case of residents on rotation) the closing hospital
41 or closing program.¹³ Thus, two of the concerns raised by the AMA and other stakeholders are
42 likely to be resolved. However, not all of the AMA’s concerns have been addressed, and CMS
43 continues to allow the closing hospital or program to allocate whatever amount of FTE cap it
44 deems fit. As such, the AMA will continue to request that CMS fully fund displaced residency
45 slots.
46

47 Also not addressed in the proposed changes, but included in AMA Policy H-310.943 (2), is the
48 desire to have CMS ensure transfer of funding for displaced residents who switch specialties.
49 Currently, CMS regulations provide funding of 1.0 FTE for an initial residency period (IRP), which
50 consists of the number of years required for residents to attain board certification in their chosen
51 specialty. However, this value does not change, even if a resident switches to a specialty that

1 requires additional training. On the other hand, if a displaced resident switches to a specialty with
2 the same IRP value, CMS will continue with the resident's 1.0 FTE funding. For any additional
3 years of training, the teaching hospital will only count the resident as 0.5 FTE.¹⁴

1 CURRENT AMA POLICY

2
3 AMA policies related to this topic are listed in the Appendix.

4
5 SUMMARY AND RECOMMENDATIONS

6
7 Suggestions have been made to better prepare for a future event similar to the closing of HUH. For
8 example, should financially struggling institutions be required to prepare financial “disaster
9 plans?”¹ The ACGME intends to amplify the voices of residents and to make sure they participate
10 in discussions on how to manage future disruptions to GME that result from instability in the health
11 care system.³ Should a special Match/SOAP (Supplemental Offer and Acceptance Program) be
12 used to process the application, interview, and offer situation, complete with Match rules (e.g.,
13 inappropriate questions about family status/plans)?³ The experience of Philadelphia-based DIOs
14 informs their suggestion, as described in their article in *Academic Medicine*, that the ACGME,
15 CMS, ECFMG, AAMC, and National Resident Matching Program (NRMP) create a “playbook” to
16 avoid the chaos experienced for HUH and its residents and program directors. They have proposed
17 the following action items.²

18
19 Recommended Action Items to Improve Relocation of Residents Displaced in Future
20 Teaching Hospital Closures

- 21
22 1. Improve alignment of CMS and ACGME policies regarding closure of programs and
23 teaching hospitals and release of CMS funding linked to individual trainees
24 2. Increase communication to sponsoring institutions, program directors, and residents
25 regarding the rights and responsibilities of residents when seeking new training
26 positions if displaced
27 3. Establish procedures and policies allowing the ACGME or the AAMC to serve as a
28 primary source of information, collaboration, and implementation of plans for
29 resident relocation
30 4. Ensure expedited decisions by ACGME Review Committees regarding temporary
31 complement increases
32 5. Establish clear guidelines as to whether, and under what circumstances, hospitals can
33 submit applications to the ACGME for accreditation of new programs
34 6. Set policies in advance regarding granting of automatic NRMP Match waivers
35 7. Explore a special NRMP-sponsored Match to relocate displaced residents
36 8. Anticipate and address potential lapses in medical professional liability coverage;
37 require training institutions to provide “tail” coverage for any displaced residents; and
38 consider creation of a national insurance “pool” to provide such coverage if necessary.

39
40 The closure of a large, long-standing teaching institution due to the financial decisions of its for-
41 profit owner may have been sudden, and certainly historic, but such closures may become more
42 frequent given the current health care financial environment; as noted, OVMC also closed during
43 2019, stranding 34 residents. The same environment may make non-profit teaching institutions also
44 vulnerable to sudden closures. The eroding of health care institutions’ financial health as a result of
45 the COVID-19 pandemic further exacerbates the current instability of our health care system.

46
47 The Council on Medical Education therefore recommends that the following recommendations be
48 adopted and the remainder of this report be filed:

- 49
50 1. That our AMA rescind Policy H-310.943 (2), “Closing of Residency Programs,” as having
51 been fulfilled by this report. (Rescind HOD Policy)

- 1 2. That our AMA ask the Centers for Medicare & Medicaid Services (CMS) to stipulate in its
2 regulations that residency slots are not assets that belong to the teaching institution.
3 (Directive to Take Action)
4
- 5 3. That our AMA encourage the Association of American Medical Colleges (AAMC),
6 American Association of Colleges of Osteopathic Medicine (AACOM), and National
7 Resident Matching Program (NRMP) to develop a process similar to the Supplemental
8 Offer and Acceptance Program (SOAP) that could be used in the event of a sudden
9 teaching institution or program closure. (Directive to Take Action)
10
- 11 4. That our AMA encourage the Accreditation Council for Graduate Medical Education
12 (ACGME) to specify in its Institutional Requirements that sponsoring institutions are to
13 provide residents and residency applicants information regarding the financial health of the
14 institution, such as its credit rating, or if it has recently been part of an acquisition or
15 merger. (Directive to Take Action)
16
- 17 5. That our AMA work with the Association of American Medical Colleges (AAMC),
18 American Association of Colleges of Osteopathic Medicine (AACOM), Accreditation
19 Council for Graduate Medical Education (ACGME), and relevant state and specialty
20 societies to coordinate and collaborate on the communication with sponsoring institutions,
21 residency programs, and resident physicians in the event of a sudden institution or program
22 closure to minimize confusion, reduce misinformation, and increase clarity. (Directive to
23 Take Action)
24
- 25 6. That our AMA encourage the Accreditation Council for Graduate Medical Education
26 (ACGME) to revise its Institutional Requirements, under section IV.E., Professional
27 Liability Insurance, to state that sponsoring institutions must create and maintain a fund
28 that will ensure professional liability coverage for residents in the event of an institution or
29 program closure. (Directive to Take Action)
30
- 31 7. That our AMA continue to work with the Accreditation Council for Graduate Medical
32 Education (ACGME) to monitor issues related to training programs run by corporate
33 entities and the effect on medical education. (Directive to Take Action)

Fiscal note: \$1,000.

APPENDIX: RELEVANT AMA POLICY

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 continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund 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.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.

14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.

15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.

16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.

17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.

18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.

19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.

20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.

21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.

22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.

23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.

24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.

25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.

26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.

27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.

28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.

29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.

30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.

31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.

32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.

33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

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

1. It is AMA policy that:

A. 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.

B. 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.

C. 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.

D. 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.

E. 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.

F. 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.

G. 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.

H. 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.

I. 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.

2. Our AMA endorses the following principles of social accountability and promotes their application to GME funding: (a) Adequate and diverse workforce development; (b) Primary care and specialty practice workforce distribution; (c) Geographic workforce distribution; and (d) Service to the local community and the public at large.

3. Our AMA encourages transparency of GME funding through models that are both feasible and fair for training sites, affiliated medical schools and trainees.

4. Our AMA believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publicly report the aggregate value of GME payments received as well as what these payments are used for, including: (a) Resident salary and benefits; (b) Administrative support for graduate medical education; (c) Salary reimbursement for teaching staff; (d) Direct educational costs for residents and fellows; and (e) Institutional overhead.

5. Our AMA supports specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty.

H-310.917, "Securing Funding for Graduate Medical Education"

Our American Medical Association: (1) continues 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); (2) continues to advocate for graduate medical education funding that reflects the physician workforce needs of the nation; (3) encourages all funders of GME to adhere to the Accreditation Council for Graduate Medical Education's requirements on restrictive covenants and its principles guiding the relationship between GME, industry and other funding sources, as well as the AMA's Opinion 8.061, and other AMA policy that protects residents and fellows from exploitation, including physicians training in non-ACGME-accredited programs; and (4) encourages entities planning to expand or start GME programs to develop a clear statement of the

benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs.

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