

COUNCIL ON MEDICAL EDUCATION REPORT 3-I-09  
Securing Funding for Graduate Medical Education  
(Resolution 318, A-09)  
(Reference Committee K)

EXECUTIVE SUMMARY

CME Report 4-I-08 summarized how the ability of teaching hospitals to expand the number of resident physicians in their programs has been constrained due to funding caps imposed by the Balanced Budget Act of 1997. Compounding this issue are complex Centers for Medicare and Medicaid (CMS) rules that limit the modalities and settings in which graduate medical education (GME) can be funded. Referred Resolution 318 (A-09), introduced by the New York Delegation, asks our AMA to urge that the current methodology for calculating direct Graduate Medical Education (DGME) payments be updated to reflect the actual costs that a hospital incurs for training residents, and that the caps on Medicare's support for GME residency positions be eliminated. This report broadly addresses issues of GME funding, provides an update on how the medical workforce is essential to health care reform, and provides examples of state, regional, and Federal innovations.

Medicare is 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. However, CMS regulations for counting eligible full-time equivalents for DGME and indirect medical education payments are complex and vary. Currently, hospitals with more residents than the number that were in place at the end of 1996 receive no DGME payment for the additional residents. Adjustments to the cap have only been permitted for new programs, newly affiliated programs, and primary care residency programs in rural areas.

Several states and the Department of Veterans Affairs (VA) are using innovative GME financing approaches to take into account state or national physician workforce needs in their decisions on how many GME programs to support and in which specialties. Utah has created a system to link Medicare and Medicaid payments to meet the state's physician workforce needs; Texas lawmakers have authorized state-formula funding to expand GME; Minnesota is pooling multiple payment sources to offset the costs of clinical training and to ensure health care research; and the VA is increasing its support of the GME enterprise with a multi-year, 2,000-position expansion of resident positions in specialties of greatest need to US veterans.

The AMA has long-standing policy to advocate for the contribution by all payers for health care to fund the costs of GME (including the Federal government, states, and private payers). However, only a handful of states and the VA have found innovative ways to increase GME funding. Private insurers have consistently opposed mandates that would require them to explicitly pay a portion of GME expenses.

In 2007, the AMA provided significant input into two reports published by the Council on Graduate Medical Education that recommended 15% more funded GME positions, innovative training models, broader training venues, fewer regulatory barriers, and making the public's health the driving force for GME. In March 2009, the AMA submitted a statement to the US Senate Committee on Finance to address the AMA's commitment to working with the Committee to further develop legislation that fully funds and increases GME positions, particularly in physician shortage/underserved areas and in under-supplied specialties. The AMA also supported bills recently introduced in Congress that would increase the number of Medicare-supported GME positions. The AMA will continue to be vigilant while monitoring pending legislation to change the financing of medical services (health system reform).

HOD ACTION: Council on Medical Education Report 3 adopted as amended and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-I-09

Subject: Securing Funding for Graduate Medical Education  
(Resolution 318, A-09)

Presented by: Susan Rudd Bailey, MD, Chair

Referred to: Reference Committee K  
(Peter C. Amadio, MD, Chair)

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1 Council on Medical Education (CME) Report 4-I-08, “Securing Medicare GME Funding for  
2 Research and Ambulatory Non-hospital-Based Outside Rotations During Residency,” recommends  
3 that our American Medical Association (AMA) continue to monitor any public and/or private  
4 efforts to change the financing of medical services (health system reform) so as to advocate for  
5 adequate and appropriate funding of graduate medical education (GME), with a report back at the  
6 2009 Interim Meeting of the AMA House of Delegates (HOD).

7  
8 Referred Resolution 318 (A-09), “Reform the Methodology for Calculating Direct Graduate  
9 Medical Education Payments: Eliminate the Caps on Medicare’s Support of GME Residency  
10 Positions to Enable Teaching Hospitals to Cover Costs and Train More Physicians,” introduced by  
11 the New York Delegation and referred by the House of Delegates, asked our AMA to urge that the  
12 current methodology for calculating direct graduate medical education (DGME) payments be  
13 updated to reflect the actual costs that a hospital incurs for training residents, rather than a hospital-  
14 specific per resident amount determined by the Centers for Medicare and Medicaid Services (CMS)  
15 for all teaching hospitals. The resolution further asked that the caps on Medicare’s support for  
16 GME residency positions be eliminated, which would enable teaching hospitals to cover their costs  
17 and subsequently train more physicians.

18  
19 This report broadly addresses issues of GME funding, provides an update on how the medical  
20 workforce is essential to health care reform, and provides examples of state, regional, and federal  
21 innovations. *There are several bills being reviewed and revised by Congress that address GME*  
22 *funding as a part of health system reform. If passed, new legislation may impact GME funding.*

23  
24 **BACKGROUND – GME FUNDING**

25  
26 CME Report 4-I-08 summarized how limited funding by CMS, due to caps on the number of  
27 funded resident positions imposed by the Balanced Budget Act of 1997, restricts the flexibility of  
28 teaching hospitals to expand the number of resident physicians in their programs (Appendix A).  
29 Regulations for counting eligible full-time equivalents (FTEs) for DGME and indirect medical  
30 education (IME) payments are complex and vary widely. Currently, hospitals with more residents  
31 than the number in place at the end of 1996 receive no DGME payment for the additional residents.  
32 Adjustments to the cap have been permitted only for new programs, newly affiliated programs, and  
33 primary care residency programs in rural areas.

34  
35 Several states are using or considering new and innovative GME financing approaches that  
36 improve the ability of academic health centers and teaching hospitals to address state physician

1 workforce needs. A few states require private insurers to contribute toward funding GME, but  
2 most do not. Some private insurers consider the comparatively higher patient care payments they  
3 make to teaching-affiliated health care providers to be indirect support of GME.<sup>1</sup>

4  
5 Current CMS rules and regulations also impose limits on the settings in which GME will be  
6 reimbursed. Such limitations of funding for ambulatory and other non-hospital sites of training  
7 have concentrated GME training in limited modalities and settings, predominantly on inpatient  
8 hospital services.

9  
10 In 2007, the AMA provided significant input into two reports published by the Council on  
11 Graduate Medical Education (COGME), the entity mandated by Congress to study and advise the  
12 federal government about the nation's physician workforce. COGME recommended 15% more  
13 funded GME positions, innovative training models, broader training venues, fewer regulatory  
14 barriers, and making the public's health the driving force for any GME expansion.<sup>2,3</sup>

15  
16 AN UPDATE ON PENDING FEDERAL LEGISLATION RELATED TO MEDICAL  
17 WORKFORCE AND HEALTH SYSTEM REFORM

18  
19 On March 12, 2009, the Senate Finance Committee held a hearing entitled, "Workforce Issues in  
20 Health Care Reform: Assessing the Present and Preparing for the Future." The AMA submitted a  
21 statement for the record (Appendix B) to the committee that addresses the AMA's support for  
22 legislation that fully funds GME and increases GME positions, particularly in specialties that face  
23 shortages and in underserved areas. The statement also calls for increasing funding for Title VII  
24 health professions and diversity programs and the National Health Service Corps (NHSC),  
25 alleviating high medical student debt burdens, and reforming the Medicare physician payment  
26 system. The AMA shared the statement with the Senate Health, Education, Labor, and Pensions  
27 Committee, since Title VII, NHSC, and medical student debt issues fall under that Committee's  
28 jurisdiction.

29  
30 COGME weighed in on these issues in a May 5, 2009 letter to the US Department of Health and  
31 Human Services and key Congressional committees. COGME called for changes in physician  
32 education and practice, including:

- 33 • Moving more physician training to non-hospital settings, including rural and underserved  
34 areas;
- 35 • Making teaching hospitals and academic medical centers more accountable for how they spend  
36 the nearly \$10 billion GME funding investment by Medicare and Medicaid;
- 37 • Fixing the income disparity between primary care and specialist physicians; and
- 38 • Making GME a site for innovations in primary care delivery.<sup>4</sup>

39  
40 *The "Resident Physician Shortage Reduction Act of 2009" (S. 973 and H.R. 2251)*

41  
42 Senator Bill Nelson (D-FL) introduced legislation on May 6, 2009 that would increase the number  
43 of Medicare-supported GME positions by 15% (approximately 15,000 slots). To address  
44 undersupplied specialties and underserved areas, the legislation would increase GME slots and  
45 redirect unused slots, with a preference for primary care and general surgery, training in  
46 community health centers and other community-based venues, hospitals in states with fewer  
47 Medicare-sponsored residency slots than medical students, and to hospitals in states with low  
48 resident-to-population ratios. The remaining one-third of slots would be allocated proportionately  
49 to hospitals operating over their caps, so long as they are training at least 25% of their residents in  
50 primary care or general surgery. In addition, the bill would provide for more flexibility in allowing

1 residents to train in non-hospital settings, which is consistent with AMA policy. Finally, the bill  
2 would allow residency slots in hospitals that close to be absorbed by nearby teaching hospitals;  
3 currently, these slots are lost upon a hospital closure. The bill does not address how the proposed  
4 15% expansion of Medicare-supported GME slots will be funded, nor does it address preserving  
5 Medicare and Medicaid funding of GME and investigating additional sources to ensure adequate  
6 GME funding. Finally, the bill does not address the need to continually assess the geographic and  
7 specialty distribution physician workforce needs and how meeting these needs should be funded.  
8 The AMA supports the Nelson bill.

9  
10 *Chronology of the “America's Affordable Health Choices Act of 2009” (H.R. 3200)*

11  
12 At the 2009 Annual Meeting, the AMA adopted new policy to “support health system reform  
13 alternatives that are consistent with the principles of pluralism, freedom of choice, freedom of  
14 practice, and universal access for patients.” Based on that guidance, the AMA Board of Trustees  
15 reviewed H.R. 3200, the “America’s Affordable Health Choices Act of 2009,” and determined that  
16 H.R. 3200 was consistent with AMA policy. On June 19, the AMA provided comments to three  
17 committees in the US House of Representatives with jurisdiction over health reform (House Ways  
18 and Means, Energy and Commerce, and Education and Labor) on the Tri-Committee Proposal on  
19 Health Care Reform.

20  
21 On July 13, the House Committee on Ways and Means released draft legislative text authorizing  
22 the redistribution of unused GME positions to qualifying hospitals, with preference to hospitals that  
23 emphasize primary care training. The bill would also authorize increased training in non-provider  
24 settings; a demonstration project for qualifying teaching health centers (e.g., federally qualified  
25 health centers that develop a primary care residency program); flexibility in the GME program to  
26 cover activities outside the hospital setting (e.g., didactic conferences and seminars); redistributing  
27 GME residency slots after a hospital closure; and a study and report on medical residency training  
28 programs, including curriculum requirements. The legislation would require states to submit  
29 information annually to the Secretary of Health and Human Services (HHS) on how GME  
30 payments are being used. By December 31, 2011, the Secretary would be required, through the  
31 rule-making process, to issue goals and requirements for the use of GME funds.

32  
33 On July 14, the House Committees on Ways and Means, Energy and Commerce, and Education  
34 and Labor introduced amended versions of H.R. 3200. While this version includes many of the  
35 provisions outlined in the June 19 “Tri-Committee” draft, it also incorporates several changes of  
36 interest to medical schools and teaching hospitals. The bill:

- 37  
38 • Specifies that hospitals currently over their Medicare “cap” are among those that will receive  
39 preference under the redistribution of residency slots;  
40 • Reduces Medicare and Medicaid disproportionate share hospital (DSH) payments beginning in  
41 FY 2017 as more individuals obtain insurance;  
42 • Directs the Secretary to revise the geographic adjustment factors used by the Medicare  
43 physician and inpatient hospital payment systems;  
44 • Clarifies the sustainable growth rate (SGR) reform provisions regarding the definition of  
45 primary care services;  
46 • Creates a new program under Title VII awarding grants to eligible “teaching health centers”  
47 (such as community health centers) that participate in the demonstration project under section  
48 1502(d) of the bill. The grants would support developing new primary care residency training  
49 programs; and

- 1 • Extends through FY 2019 funding authorizations of the NHSC and many other Title VII  
2 programs, and incrementally increases funds deposited in a new Public Health Investment  
3 Fund.  
4

5 In the Senate, the Committee on Finance, chaired by Senator Max Baucus (D-MT), and the  
6 Committee on Health, Education, Labor, and Pensions (HELP), chaired by Senator Tom Harkin  
7 (D-IA), have primary jurisdiction over health care reform. The Finance Committee is responsible  
8 for the Medicare and Medicaid provisions in health care reform, including GME funding, while the  
9 HELP Committee covers Title VII, Title VIII, NHSC, and medical student debt issues. On July 15,  
10 2009, the HELP Committee approved the Affordable Health Choices Act, which has many similar  
11 provisions in the House version, including adding programs to train more primary care physicians.  
12

13 *America's Healthy Future Act of 2009 (Baucus proposal)*  
14

15 On September 16, Senator Baucus released the details of a draft health care reform proposal.  
16 Senators filed more than 500 amendments to the Baucus proposal, some of which would make  
17 major changes to strengthen primary care and other workforce improvements.  
18

19 The proposal includes several provisions related to GME, including redistribution of unused GME  
20 slots with priority given to increasing training in primary care and general surgery. In this  
21 provision, the Centers for Medicare and Medicaid Services (CMS) would calculate the number of  
22 unused resident slots over the last 3 fiscal years. Unused slots would be defined as the difference  
23 between total available resident slots and a hospital's actual full-time equivalent (FTE) of residents.  
24 Based on this calculation, 80% of unused slots would be included in a pool for redistribution. The  
25 committee adopted amendments by Senators Jeff Bingaman (D-NM) and Bill Nelson (D-FL) that  
26 would ensure that 50% of the GME slot redistribution in the underlying chairman's mark is  
27 prioritized for rural and other underserved communities.  
28

29 The HHS Secretary would be required to increase the otherwise applicable resident limit for each  
30 qualifying hospital that submits a timely application. When determining the increase in a hospital's  
31 otherwise applicable resident limit, the Secretary would take into account the demonstrated  
32 likelihood that: (1) a hospital would fill the positions within the first three cost reporting periods  
33 beginning on or after July 1, 2010; (2) a hospital would take part in an innovative delivery model  
34 that promotes quality and care coordination, such as payment bundling; and (3) a hospital would  
35 have an accredited rural training track residency program. The Secretary would distribute the  
36 increase in the otherwise applicable resident limit based on the following factors: (1) to hospitals  
37 located in states with resident to population ratios in the lowest quartile; (2) to hospitals located in a  
38 state that is among the top ten states in terms of the ratio of the total population living in a health  
39 professional shortage area determined by HHS as of the date of enactment compared to total  
40 population of the state based on the most recent state population projections by the US Census  
41 Bureau; and (3) to hospitals located in rural areas.  
42

43 The per resident amounts (PRAs) for the resident positions distributed under this provision would  
44 equal the hospital's PRAs for primary and non-primary care positions for the purposes of  
45 calculating direct graduate medical education (DGME) payments. The indirect medical education  
46 (IME) adjustment for these resident positions distributed under this provision would be reimbursed  
47 at the full IME adjustment factor.  
48

49 The Baucus proposal also allows for greater flexibility for placing residents in non-hospital settings  
50 for a portion of their training, preserving and distributing GME training slots when teaching  
51 hospitals close, and establishing a Workforce Advisory Committee. It would also establish a

1 5-year, 10% bonus payment for certain evaluation and management services provided by primary  
2 care practitioners.

3  
4 The Committee also adopted another amendment by Senator Bingaman that would establish a grant  
5 program to provide community-based training sites funding to establish and operate residency  
6 programs such as teaching health centers to improve access to primary care physicians. Qualified  
7 teaching health centers would be eligible for payments for DGME expenses and other indirect  
8 expenses associated with operating approved GME training programs. These programs will be in  
9 addition to existing Medicare-supported residency slots and must meet criteria for accreditation (as  
10 set forth by either the Accreditation Council for Graduate Medical Education or the American  
11 Osteopathic Association). The Secretary would determine the basis of payment and funding  
12 calculations for both the DGME and IME payments and would declare regulations under existing  
13 rulemaking requirements to establish this program.

14  
15 Once the Senate bills are merged into a final legislative bill, some of the amendments that passed in  
16 the Senate Committees may be modified or eliminated, and this section will be updated.

#### 17 18 *Funding to Expand Health Professions Training*

19  
20 On July 28, 2009, HHS Secretary Kathleen Sebelius, announced the availability of \$200 million of  
21 recovery act funding to expand health professions training. She announced that, "Health system  
22 reform cannot happen without an adequate supply of well-trained, well-distributed providers."<sup>5</sup>  
23 The funds are expected to train approximately 8,000 students and credentialed health professionals  
24 by the end of fiscal year 2010. The funds are part of the \$500 million allotted to HHS' Health  
25 Resources and Services Administration (HRSA) to address workforce shortages under the  
26 American Recovery and Reinvestment Act (ARRA). Funding will go towards:

- 27
- 28 • Supporting health professions scholarships and loans.
- 29 • Bolstering primary care training programs.
- 30 • Helping health professions training programs purchase needed equipment.
- 31 • Increasing health professions diversity.
- 32 • Strengthening the public health workforce.
- 33

#### 34 *Summary*

35  
36 As the debate on health system reform continues in Congress, federal legislators are becoming  
37 more aware of the integral relationship between reform and health care workforce, in part through  
38 lobbying and educational efforts by the AMA and other organizations. The Macy Foundation, for  
39 example, recently noted that if health system reform is to achieve the goal of providing access and  
40 improving health, then significant changes will be needed in both the educational and  
41 reimbursement systems.<sup>6</sup>

#### 42 43 **THREE STATE MODELS AND THE DEPARTMENT OF VETERANS AFFAIRS**

44  
45 Examples of state and federal programs that serve as potential models for national GME financing  
46 are described below.

1 *Utah – Medicare and Medicaid Payments Linked to State Medical Workforce Goals*

2  
3 Historically, teaching hospitals have not been required by Medicare or Medicaid to take into  
4 account state or national physician workforce needs in their decisions on how many GME  
5 programs to support and in which specialties. As nearly all teaching hospitals are located in cities,  
6 only a small fraction of Medicare GME payments go to rural programs. Utah created a structure  
7 and process for linking GME funding to rational planning to meet Utah’s future physician  
8 workforce needs. The Utah Medical Education Council (UMEC) was created by state law in 1997,  
9 to be responsible for receiving and disbursing all Medicare DME and IME and Medicaid payments.

10  
11 UMEC’s efforts are focused on expanding physician residency programs in specialties with  
12 shortages, and increasing the percent of graduating residents who stay in Utah to practice, as well  
13 as those who practice in rural areas. A new waiver program obtained from CMS allows UMEC to  
14 change the flow of GME dollars to influence residency programs and better meet the state’s  
15 workforce needs. UMEC has been successful in substantially increasing federal GME funding for  
16 the state. Utah’s GME planning initiative and the avenues used by Utah to increase its federal  
17 Medicare and Medicaid GME payments may be a model for other states or regions, especially  
18 those with only one or two medical schools and a small number of teaching hospitals, such as  
19 Nevada and Hawaii.<sup>7</sup>

20  
21 Gar Elison (former director of UMEC), noted that

22  
23 “Under the waiver, programs bill hospitals a lesser amount because the direct GME dollars  
24 now flow to the program directors. Program directors who hire the residents are held  
25 accountable for achieving the state workforce objectives. Directors are also responsible for  
26 meeting accreditation requirements and filling the positions in the program. In short, the  
27 waiver rationalizes the process and places responsibility with those who have the authority to  
28 link training with workforce needs.”<sup>8</sup>

29  
30 *Texas – State Appropriations Supplement Federal Funding of GME*

31  
32 Texas is the second most populous state, but its ratio of resident physicians to population is 20%  
33 below the national average, and the state ranks 42nd among the 50 states in the ratio of physicians  
34 to population. Growth in medical school enrollments has been flat for 20 years, and stakeholders  
35 in medical workforce planning have called for significant increases in new physicians,  
36 recommending a 30% increase in medical school enrollments and a 15% increase in GME slots.  
37 Medical schools and teaching hospitals in Texas have limited funding available to expand GME,  
38 and the shortage of GME slots is forcing some medical students to leave the state upon graduation.  
39 Graduates of public medical schools take with them more than \$200,000 of state investment in  
40 their medical school education; it is likely that many will not return to Texas.<sup>9</sup>

41  
42 In 2009, Texas lawmakers authorized \$60.45 million in state formula state funding in both 2010  
43 and 2011 for GME. Although this funding is intended to assist in the effort to create new GME  
44 positions, it is not sufficient to pay for all the predicted growth. For example, the current state  
45 GME funding formula represents less than half of estimated faculty costs for GME in Texas. In  
46 addition, to retain medical students in Texas, an estimated 1,000 new GME slots are required by  
47 2011. Plans for 2010 include producing more home-grown physicians through adequate state  
48 formula funding of medical school expansions and GME slots.<sup>10</sup>

1 *Minnesota – Pooling Multiple Payment Sources for GME*

2  
3 The Minnesota Department of Health (MDH) established the Medical Education and Research  
4 Costs (MERC) Program in 1997 to support certain medical education activities and to compensate  
5 hospitals and clinics for a portion of the costs of clinical training. The program distributes grants to  
6 clinical training sites throughout the state to offset the higher cost structures and lost patient care  
7 revenue of teaching institutions so they can remain competitive in the health care marketplace. The  
8 funds are also used to ensure continued health-care research in Minnesota.<sup>11</sup>

9  
10 Although the formula governing the MERC distribution has changed over the years, the MERC  
11 program has distributed more than \$450 million in grant funds to hospitals, clinics, and other  
12 clinical training sites throughout Minnesota. Most of the MERC distribution has been awarded to  
13 large teaching hospitals in the Twin Cities area and in Rochester. Funding for the MERC program  
14 has come from different sources, including the General Fund, a one-time tobacco endowment, a  
15 dedicated cigarette tax, and the Medicaid program. Medicaid funds currently account for  
16 approximately 90% of the annual distribution to MERC.<sup>11, 12</sup> The MERC Advisory Committee was  
17 established to evaluate and recommend changes to the distribution formula to ensure the financial  
18 viability of institutions and clinical training sites with low numbers of eligible trainee FTEs.<sup>13</sup>

19  
20 *Summary*

21  
22 These three state initiatives notwithstanding, a study published by the Robert Graham Center  
23 showed that even as some states have demonstrated a willingness to fund expansion of medical  
24 education (new medical schools and expanded enrollments), there is remarkably little direction or  
25 funding to purposefully tailor physician training in GME to the future needs of the population.<sup>14</sup>

26  
27 *The Department of Veterans Affairs' Expansion of GME*

28  
29 The Department of Veterans Affairs (VA) is the second largest source of funding for GME (after  
30 Medicare and Medicaid). A federally chartered external advisory committee on veterans health  
31 affairs resident education affirmed the VA's role in provision of GME and recommended that the  
32 VA increase its proportional support of the national GME enterprise with a multi-year, 2,000-  
33 position expansion. Chang notes that the goals of the GME enhancement are to "address physician  
34 workforce shortages by expanding resident positions in specialties of greatest need to US veterans  
35 and the nation; address the uneven geographic distribution of residents to improve access to care;  
36 and foster innovative models of education, while enhancing the VA's leadership role in GME."<sup>15</sup>

37  
38 During the first three phases of the GME Enhancement initiative, 974 physician resident positions  
39 were awarded to 83 facilities in 66 specialty training programs.<sup>16</sup> Internal medicine and its  
40 subspecialties represent the largest cohort of added positions. Internal medicine core-program  
41 positions increased by 146 (15% of all positions awarded to date), and internal medicine  
42 subspecialties saw an increase of 279 (29% of awarded positions). The VA Enhancement initiative  
43 has been successful in reversing a downward trend in VA-funded internal medicine positions as  
44 reallocations of these positions to other specialties had occurred over the past 8 years. However,  
45 the total internal medicine positions funded by the VA have still declined overall, from 3,483 in  
46 academic year 2000-2001 to 3,302 in 2008-2009.<sup>15</sup>

47  
48 The VA Office of Academic Affiliations has developed three requests for proposals (RFPs) to  
49 create approximately 325 additional permanent resident positions in academic year 2010-2011  
50 (residents start July 1, 2010). Subsets of the GME enhancement for which RFPs are requested  
51 include critical needs and emerging specialties, new affiliations, new VA sites of care and

1 educational innovations. VA facilities will have the opportunity to apply for additional new  
2 (“base” or permanent) positions over the subsequent 2 years if VA resources permit.<sup>16</sup>

### 3 4 AMA POLICY

5  
6 AMA Policies H-305.929, “Proposed Revisions to AMA Policy on the Financing of Medical  
7 Education Programs,” D-305.967, “The Preservation, Stability, and Expansion of Full Funding for  
8 Graduate Medical Education,” and D-305.963, “Securing Medicare GME Funding for Research  
9 and Ambulatory Non-Hospital Based Outside Rotations During Residency” (AMA Policy  
10 Database; see Appendix C) are relevant to this discussion.

11  
12 These AMA policies state that:

- 13
- 14 • Adequate and stable funding should be available to support quality undergraduate and graduate  
15 medical education programs. Our AMA and the federation should advocate for medical  
16 education funding.
- 17 • Diversified sources of funding should be available to support medical schools’ multiple  
18 missions, including education, research, and clinical service. Reliance on any particular  
19 revenue source should not jeopardize the balance among a medical school’s missions.
- 20 • Funding for graduate medical education should support the training of resident physicians in  
21 both hospital and non-hospital (ambulatory) settings.
- 22 • Our AMA opposes regulatory and legislative efforts that reduce funding for GME from the full  
23 scope of resident educational activities that are designated by residency programs required for  
24 the accreditation of residency programs and the board certification of their graduates (e.g.,  
25 didactic teaching, community service, off-site ambulatory rotations, etc.).

### 26 27 DISCUSSION

28  
29 Medicare is still the single largest funding source for GME, and CMS funding helps offset some of  
30 the costs associated with educating residents, caring for patients in teaching hospitals who often  
31 require more intense and complex care, and other special missions of teaching hospitals.  
32 Sponsoring institutions have found it difficult to maintain their net income, which has depended in  
33 part on revenue generated by resident service and CMS funding.<sup>3, 17, 18</sup>

34  
35 There are varying opinions on the future physician workforce. Dr. Richard Cooper, Professor of  
36 Medicine and Senior Fellow at the Leonard Davis Institute of Health Economics at the University  
37 of Pennsylvania, for example, believes that there is a looming doctor shortage, a woefully  
38 inadequate number of residency positions, and that progress in responding to this crisis has been  
39 stalemated by a broadly accepted view that there is “unexplained” geographic variation in both  
40 physician supply and health care spending.<sup>19, 20, 21</sup> Researchers at Dartmouth and others suggest that  
41 geographic regions with more physicians experience greater health-care costs with no  
42 accompanying improvements in outcomes or satisfaction and believe that training more primary  
43 care physicians and fewer specialists as well as improving what doctors do will be necessary.<sup>22</sup>

44  
45 COGME has focused attention on physician shortages and factors affecting specialty choice. This  
46 is especially important because of the growing and aging population, advances in medicine that  
47 lead to longer life, and an aging physician workforce. A 2005 COGME report projected that by  
48 2020, the shortage of physicians will reach 85,000. In November 2008, the Association of  
49 American Medical Colleges estimated a shortage of at least 124,000 physicians by 2025 across all  
50 specialties. An article published in the *Journal of the American Medical Association (JAMA)* in

1 2008 projects that at least 21,000 additional residency positions will be needed within the next  
2 decade to keep pace with the projected increment of more than 5,300 additional MD and DO  
3 graduates from US allopathic and osteopathic medical schools.<sup>23</sup> Furthermore, a December 2008  
4 Institute of Medicine (IOM) report calls for reductions in duty hour shifts for resident physicians to  
5 enhance patient safety. If the IOM recommendations are adopted, one possible outcome will be an  
6 increased demand for GME positions to help cover the shortage in resident workforce. Finally, the  
7 passage of universal health-insurance coverage would also significantly impact the demand for  
8 physician services in the United States.

9  
10 Being responsive to the medical care needs of US citizens will also require greater flexibility in the  
11 training of physicians. Resident physicians currently spend most of their time caring for acutely ill  
12 hospital inpatients. This hospital-based experience gives residents important skills for treating  
13 serious illnesses but may not provide sufficient education and training in nonhospital and  
14 community-based settings. The complex rules imposed by CMS currently limit the modalities and  
15 settings in which GME can qualify for CMS funding, making it difficult for programs to provide  
16 residents the opportunity to care for patients across the continuum of diseases and in multiple  
17 settings.

18  
19 AMA has long-standing policy to advocate for the contribution by all payers for health care  
20 (including the federal government, states, and private payers) to fund both the direct and indirect  
21 costs of GME. Specifically, the AMA agrees with COGME's recommendations and supports  
22 federal legislative initiatives that would provide new money for GME and would lift the current  
23 cap on Medicare-supported residency positions, especially in physician shortage/underserved areas  
24 and in under-supplied specialties. However, private insurers have consistently opposed mandates  
25 that would require them to pay a portion of GME expenses.<sup>24</sup>

## 26 27 SUMMARY AND RECOMMENDATIONS

28  
29 The Centers for Medicare and Medicaid Services (CMS) caps on the number of funded resident  
30 trainees imposed by the Balanced Budget Act of 1997 have restricted the ability of teaching  
31 hospitals to expand the number of resident physicians in their programs. In addition, rules for  
32 federal funding of graduate medical education (GME) have created financial, administrative, and  
33 other barriers to relevant academic and clinical educational experiences that are essential for a well  
34 trained and capable medical workforce. Currently, many deem the overall physician pipeline as  
35 inadequate, especially in light of specific needs by specialty, demographics, and region. Although  
36 some states and the Department of Veterans Affairs have found innovative ways to increase GME  
37 funding, most states have not.

38  
39 The Council on Medical Education, therefore, recommends that the following be adopted in lieu of  
40 Resolution 318 (A-09) and the remainder of the report be filed.

- 41  
42 1. That our American Medical Association (AMA) reaffirm AMA Policies H-305.929, D-  
43 305.967, and D-305.963 on the financing of graduate medical education and continue to  
44 advocate for funding for training in non-hospital sites and for all training activities required  
45 in graduate medical education programs accredited by the Accreditation Council for  
46 Graduate Medical Education or the American Osteopathic Association. (Reaffirm HOD  
47 Policy)

- 1       2. That our AMA continue to be vigilant while monitoring pending legislation that may  
2       change the financing of medical services (health system reform) and advocate for expanded  
3       and broad-based funding for graduate medical education (from federal, state, and  
4       commercial entities) with a report back to the House of Delegates. (Directive to Take  
5       Action)  
6
- 7       3. That our AMA continue to advocate for graduate medical education funding that reflects  
8       the ~~specialty specific, demographic, and regional geographic~~ physician workforce needs of  
9       the nation. (Direction to Take Action)

Fiscal Note:     \$2500 for staff time.

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## Appendix A

### Medicare Funding

The Balanced Budget Act (BBA) of 1997 introduced a cap on funded GME positions and limited the number of allopathic and osteopathic medical residents that would be counted for purposes of calculating Medicare direct graduate medical education (DGME) payment. [BBA Section 1886 (h) (4) (E) of the Act, as added by section 9202 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (Pub. L. 99-272)]. This legislation set the number of Medicare GME-funded resident positions to the number of approved positions the institution had in place in December 1996. Coupled with cuts to Medicare GME funding in the BBA of 1997 and the Balanced Budget Refinement Act of 1999, sponsoring institutions have found it difficult to maintain their bottom line that has historically depended on resident service and to expand their residency training programs even when they have sufficient educational opportunities to support growth in their GME positions. 1, 2, 3

DGME reimbursement covers salary, fringe benefits, attending physician compensation for residents in an approved program working in all areas of the hospital complex.<sup>4</sup> DGME payment is calculated based on the institution's number of residents in an approved program in a current year and a historical average GME cost per resident in a base year.<sup>5</sup> This count of residents is the most difficult aspect of the regulations, because resident physicians are "weighted" by the number of years of their residency and how much time they spend in the hospital. 1, 6

The BBA and subsequent regulations also permit indirect medical education (IME) funds to be paid to select outpatient facilities to cover the indirect costs associated with training residents. Although the IME payment is based on an institution's number of residents in approved programs, it is not given for services furnished by residents in training, but, rather, for the higher operating costs incurred by the teaching institution as a class. IME funds cover the ordering of more tests, longer patient stays, sicker patient populations, and greater technological needs, and offset the lack of private insurance's contribution to GME. 1, 6

The rules on Medicare payment for residents working both inside and outside of approved programs are complex. The proper application of these rules may require the collaboration of hospital financial and compliance officers, administrators of a hospital's graduate medical education programs, and physicians who supervise the trainees whose time is at issue. Such collaboration is essential to ensure appropriate Medicare payments and minimize compliance risk.<sup>5</sup>

Also to be considered, are residents who may spend time in residency programs at locations other than the sponsoring institution. When residents split their time among hospitals, their time must be allocated as partial FTEs at each facility. If a resident spends time in more than one hospital or in a non-provider setting, the resident counts as partial FTE based on the proportion of time worked at the hospital to the total time worked. A part-time resident counts as a partial FTE based on the proportion of allowable time worked compared to the total time necessary to fill a full-time residency slot.<sup>6</sup>

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Appendix B

Statement

of the

American Medical Association

to the

Committee on Finance  
United States Senate

Re: Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future

March 12, 2009

25 Massachusetts Avenue, NW, Suite 600  
Washington, DC 20001  
Division of Legislative Counsel

(202) 789-7425

On behalf of our physician and medical student members, the American Medical Association (AMA) appreciates the opportunity to submit a statement on our nation's health care workforce needs. We hope our comments provide you with further guidance on legislative mechanisms needed to address the looming health care workforce shortages. We commend Chairman Baucus, Ranking Member Grassley, and Members of the Committee on Finance for recognizing that the health care workforce is a vital component to health care reform and access to care.

Workforce experts predict that a growing and aging population, advances in medicine that lead to longer life, an aging physician workforce, and universal coverage will significantly impact supply of and demand for physician services in the U.S. There is agreement from many sources that the U.S. faces a physician shortage. A 2005 Council on Graduate Medical Education (COGME) report projected that by 2020, the shortage of physicians will reach 85,000. In November 2008, the Association of American Medical Colleges (AAMC) estimated a shortage of at least 124,000 physicians by 2025 across all specialties. It is critical that Congress, working with the physician community and others in the health care industry, take immediate action to address the future physician workforce needs of the nation, particularly in specialties that face shortages and in underserved areas.

## Graduate Medical Education

The current expansion of medical schools and growth in medical student enrollments will not address the physician shortage unless the number of U.S. graduate medical residency slots are increased as well. Only by increasing the number of physicians in residency training will the number of practicing physicians in the workforce grow. A growing and aging patient population will directly benefit from an increase in the number of practicing physicians. Therefore, fully funding graduate medical education (GME) positions and lifting the cap on Medicare-supported GME slots are essential steps to ensure that we have a fully trained health care workforce to serve the future needs of patients.

The Balanced Budget Act (BBA) of 1997 capped the number of medical residents each teaching hospital could claim for reimbursement under Medicare. Medicare does not generally reimburse teaching hospitals for training residents if the number exceeds the capped number of residency slots. COGME recommends removing the current cap on residency slots and increasing the number of funded slots by 15 percent. Additionally, a peer-reviewed study published in the *Journal of the American Medical Association (JAMA)* in 2008 projects an additional 21,000 residency spots will be necessary within the next decade. A 2008 Institute of Medicine (IOM) report calls for the reduction in duty hour shifts for resident physicians in order to enhance patient safety. Expanding the number of GME positions would also help cover the shorter shifts if the IOM recommendations are adopted.

The AMA also recommends lifting the cap on Medicare-funded residency slots for undersupplied specialties and underserved areas, and fully funding GME by preserving Medicare and Medicaid funding of GME and investigating additional sources of GME funding. In addition, we recommend allowing greater flexibility in GME and other programs to encourage training in non-hospital settings while enhancing the quality of training for resident physicians. Finally, we recommend bringing together a variety of local, regional, and national stakeholders including representatives from state medical schools, academic health centers, teaching hospitals, physician specialty societies, public health, and policy leaders to determine and make recommendations on geographic and specialty distribution physician workforce needs and how meeting these needs should be funded.

## Title VII Health Profession and Diversity Programs and the National Health Service Corps

Through low interest loans, loan guarantees, loan repayment programs, and scholarships to students, as well as grants and contracts to academic institutions and non-profit organizations, Title VII of the Public Health Service Act is an essential component of the nation's health care safety net. Title VII programs help increase the supply of primary medical care and preventive medicine specialists and help ensure that health care professionals are trained to provide quality care, represent the diverse makeup of the general population, and are available to communities across the country, particularly those in underserved areas. The Title VII primary care cluster is the only federal funding dedicated specifically to the education and training of the primary care workforce. Data indicates that Title VII funded programs have increased the family physician workforce in rural and low income communities.

While the diversity of the population of physicians-in-training and in practice is far from optimal, Title VII programs have helped to increase the diversity of the workforce. They include vital health professions programs such as Centers of Excellence, Scholarships for Disadvantaged Students, Health Careers Opportunity Program, and Faculty Loan Repayment Program/Minority Faculty Fellowship Program that provide both policy leadership and support for health professions

workforce enhancement and educational infrastructure development. Increasing funding for Title VII programs would improve the geographic distribution, quality, and diversity of the health professions workforce. Area Health Education Centers and Regional Centers for Workforce Analysis are necessary to improve the supply, distribution, diversity, and quality of the health care workforce, ultimately increasing access to health care in medically underserved areas.

Congress last reauthorized these Title VII programs in 1998. Since then, many of the Title VII health professions and diversity programs have faced significant cuts. The AMA was pleased that H.R. 1, the “American Recovery and Reinvestment Act of 2009,” (P.L. 111-5) included needed health professions funding that could be allocated toward Title VII health profession and diversity programs. Reauthorizing and fully funding these programs are crucial to developing a well-prepared, well-distributed, and diverse health care workforce.

The National Health Service Corps (NHSC) is also vital to addressing the health care needs of our nation. The NHSC recruits and retains primary care physicians (i.e., general internal medicine, general psychiatry, general pediatrics, OBGYNs, etc.) and other health care providers (i.e., nurse practitioners, dentists, mental and behavioral health professionals, physician assistants, and dental hygienists) in underserved rural areas by providing incentives through loan forgiveness programs and scholarships. The NHSC improves access to health care for underserved areas, provides incentives for practitioners to enter primary care, reduces the financial burden that the cost of health professions education places on new practitioners, and helps ensure access to health professions education for students from all backgrounds. Since its creation, the NHSC consistently has received significantly more applications for positions than it is able to support with the funding provided by Congress.

However, in the past five years funding for the NHSC has been cut by over \$47 million, a 27 percent reduction from the \$171 million in FY 2003 that was already insufficient to meet the nation’s health care needs. As a result, the NHSC reduced the number of new annual scholarship and loan repayment awards by over 30 percent during that period. While H.R. 1 provides funding for the NHSC over the next 2 years, the NHSC estimates it will only result in an additional 4,250 NHSC practitioners.

The AMA recommends restoring full funding for Title VII health profession and diversity programs and increasing funding for the NHSC program. For FY 2010, the AMA recommends a combined appropriation of \$235 million for the NHSC. This figure represents the amount authorized under the “Health Care Safety Net Act of 2008” (P.L. 110-355) for NHSC Recruitment (\$156,235,150), with a proportionate increase in the NHSC Field appropriation.

#### International Medical Graduates

Many communities, including rural and low-income urban areas, have problems attracting physicians to meet their health care needs. To address these unmet needs, many of these communities have turned to international medical graduates. A program that is essential for addressing physician shortages in underserved areas is the J-1 Visa waiver program, which allows international medical graduates to remain in the U.S. after their residency if they have agreed to practice in a medically underserved location for at least 3 years, working specifically in H-1B Temporary Worker status. The AMA supports permanent reauthorization of the Conrad State 30 J-1 Visa Waiver Program; a program authorizing state health agencies to place physicians annually in either federally designated Health Professional Shortage Areas or Medically Underserved Areas where it is difficult to recruit physicians. The AMA also recommends increasing the number of

Conrad 30 program slots and exempting from immigration caps physicians with H-1B visas who have completed their J-1 visa waiver service requirements.

### Medical Student Debt

With an average debt for medical student graduates of \$155,000, debt plays a major role in medical students' career decisions, as well as discouraging individuals from socioeconomically-disadvantaged backgrounds from applying to medical school. High medical student debt is a significant hardship throughout the loan repayment period, especially during the three to seven years of training in medical residency programs. The average first-year stipend for medical residents is low, and makes it difficult for residents to train in urban areas where the cost of living is high. The high debt burden that many medical graduates face often influences their career choices. Borrowers with high loan debt are often deterred from entering public health service, practicing medicine in underserved areas, starting a career in medical education or research, or practicing primary care medicine. Loan deferment and forgiveness programs are necessary for ensuring that health care professionals represent the diverse makeup of the general population, and are available to communities across the country, particularly those in underserved areas.

In order to alleviate high medical student debt burdens, the AMA recommends creating more opportunities for debt relief through tuition assistance and loan forgiveness for service programs, low interest rates for medical student loans, income tax exemptions for medical student scholarships, inclusion of dependent costs in the "cost of attendance" definition to permit trainees to claim dependent costs in loan eligibility calculations, and expansion of loan forgiveness programs to medical teaching faculty. Loan forgiveness should especially be considered for primary care and other specialties with critical shortages. Additionally, the AMA strongly supports reestablishing the "20/220 pathway" for economic hardship loan deferment. The elimination of the economic hardship deferment, also known as "the 20/220 pathway," which expires on June 30, 2009, requires new medical residents to choose between making required monthly payments under the newly created income-based repayment program or deferring under forbearance, which dramatically increases their repayment costs. Reinstating the 20/220 pathway would allow medical residents to better manage their high debt burden and focus on their medical training and development during the critical and challenging years of residency.

### Medicare Physician Payment System Reform

We need to find ways to keep practicing physicians caring for seniors and encourage the best and brightest students to become physicians; permanent Medicare physician payment reform will help us achieve that goal. As a result of the flawed Medicare physician payment formula, known as the sustainable growth rate, or SGR, physicians face cumulative cuts of over 40 percent in the coming decade, including a 21 percent cut scheduled for January 1, 2010. Physicians cannot absorb these steep losses, especially when physician practice costs are expected to increase by at least 20 percent at the same time that rates are being cut. In addition, these cuts affect physician workforce issues. As discussed above, the COGME and AAMC are already predicting severe physician shortages across all specialties by 2020 and 2025, respectively. Other studies forecast shortages in a number of specialties, including primary care, cardiology, emergency medicine, general surgery, geriatric medicine, oncology, neurosurgery, and thoracic surgery. Multi-year cuts in Medicare are nearly certain to exacerbate these shortages by making medicine a less attractive career and encouraging retirements among the 35 percent of physicians who are 55 or older.

## Conclusion

The AMA appreciates the leadership of the Committee and remains committed to working closely with you on further developing legislation in order to ensure that the nation has an adequate, fully trained, accessible health care workforce to meet the needs of our growing and aging population. Addressing the current and future physician workforce needs of the nation is a critical component of health care reform. Fully funding GME and increasing GME positions, particularly in specialties that face shortages and in underserved areas, bringing together a variety of health care experts to assess and make recommendations on our physician workforce needs and how meeting these needs should be funded, increasing funding for the Title VII health profession and diversity programs and the NHSC, alleviating high medical student debt burdens, and reforming the Medicare physician payment system will help to ensure that every American has access to physicians and high-quality health care in the coming years.

## Appendix C

Existing AMA policy calls for the preservation, stability, and expansion of full funding for GME.

AMA policy H-305.929 Proposed Revisions to AMA Policy on the Financing of Medical Education Programs states that:

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)

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 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. (Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08)

#### D-305.963 Securing Medicare GME Funding for Research and Ambulatory Non-Hospital Based Outside Rotations During Residency

Our AMA will: 1. Advocate for the Centers for Medicare and Medicaid Services (CMS) (both federal Medicare and federal/state Medicaid) funding for the time residents and fellows spend in research, didactic activities, and extramural educational activities required for the Accreditation Council for Graduate Medical Education (ACGME) accreditation during their training. 2. Continue to work with organizations such as the Association of American Medical Colleges (AAMC) and the Council on Graduate Medical Education (COGME), to make recommendations to change current Graduate Medical Education (GME) funding regulations during residency training, which currently limit funding for research, extramural educational opportunities, and flexible GME training programs and venues. 3. Monitor any public and/or private efforts to change the financing of medical services (health system reform) so as to advocate for adequate and appropriate funding of GME. 4. Prepare a Council on Medical Education report for the 2009 Interim Meeting that broadly addresses issues of GME funding that includes examples of successful state and regional innovations. 5. Advocate for funding for training physician researchers from sources in addition to CMS such as the National Institutes of Health, the Agency for Healthcare Research and Quality, the Veterans Administration, and other agencies. (CME Rep. 4, I-08)