

2020

Compendium of Graduate Medical Education Initiatives Report



Introduction

The American Medical Association Council on Legislation and the AMA Council on Medical Education are continuing their partnership focusing on viable ways to improve graduate medical education (GME) to ensure medical students have the opportunity to fulfill training requirements and become practicing doctors. Workforce experts continue to predict that the U.S. will face a significant physician shortage for both primary care and specialty physicians over the next 10+ years if training positions are not expanded.

The projected shortage of between 54,100 and 139,000 physicians by 2033 includes both primary care (21,400 and 55,200) and specialty care (33,700 and 86,700). Among specialists, the study projects a shortage of between 9,300 and 17,800 medical specialists; 17,100 and 28,700 surgical specialists; and 17,100 and 41,900 other specialists, including pathologists, neurologists, radiologists and psychiatrists by 2033.ⁱ To adequately address these concerns, this document seeks to provide background regarding the challenges faced by the current GME system. This document also outlines GME initiatives including those by the AMA, private entities, and federal and state government that we hope will inform future GME advocacy.

An overview of GME

GME programs account for nearly three-quarters of the U.S. Department of Health & Human Services' (HHS) health workforce expenditures, and may be a strong policy lever to impact patient access to care because the number of medical school graduates who obtain and complete a residency determines the size of the physician workforce, and the types of residencies they complete determine its specialty composition. Also, where physicians complete their residencies often affects where they establish their practices. As a result, policies that alter federal funding for GME may impact future physician supply and could be used to address certain workforce concerns.ⁱⁱ

Although the federal government is not the sole contributor to GME funding, it is by far the largest single source, primarily through Medicare funding. Medicare funding to support GME programs comes from direct GME funding and indirect GME funding. Direct GME (DGME) funding represents approximately one-third of all Medicare support for GME. The intent is for DGME

to support the direct costs of running a residency program and covers salaries for residents and faculty as well as educational support. Indirect GME (IME) payments, which represent the majority of Medicare GME funding, are calculated based on the size of a hospital, the number of residents supported and the number of Medicare inpatients treated. IME payments are in addition to payments an institution receives from Medicare reimbursement and are meant to offset the costs of maintaining an educational program that are not captured by Medicare reimbursement. Both IME and DGME payments are derived by complex formulas and are not designed to account for differences in costs resulting from training residents in different specialties. The Department of Veterans Affairs, Medicaid and the Children's Health Insurance Program are other federal sources of GME funding of varying levels. In addition, the Army, Navy and Air Force support their own in-house residencies and fellowships to provide for the future physician workforce needs of those services.

A brief summary of current GME fundingⁱⁱⁱ

Program Name <i>Control over trainees</i>	Total Funding	Number of Trainees	Cost Per Trainee
MANDATORY FUNDING			
Medicare GME Payments The number of Medicare-supported residents and per-resident payment amount is capped for each hospital, but hospitals determine staffing needs and types of residents with the exception of certain primary care residents.	FY2015 (est.): \$10.3 - \$12.5 billion	FY2015 (est.): 85,712 - 87,980 FTE (DGME) slots 85,578 - 88,416 FTE (IME) slots	FY2015 (est. average): \$112,000 - 129,000 per FTE
Medicaid GME Payment States are permitted to make these payments using their own criteria to determine which providers are eligible for payments.	N/A	N/A The Medicaid program does not require states to report these data.	N/A. The Medicaid program does not require states to report these data.
Teaching Health Centers GME Payment Program Funding to applicant teaching health centers that meet the program's eligibility requirements.	FY2018: \$126.5 million (est.)	AY2016-AY2017: 742 FTE slots 771 total residents trained	N/A
DISCRETIONARY FUNDING			
Veterans Affairs GME Payments VA facilities determine their staffing needs and the number and type of residents supported.	FY2017: \$1.78 billion	AY2016-AY2017: 11,000 FTE slots and > 43,565 residents spent part of their training at a VA facility	FY2015 (est.): \$137,792/resident
Children's Hospital GME Payment Program Grant funding awarded to applicant children's hospitals that meet the program's eligibility requirements.	FY2019: \$325billion	FY2016-FY2017 58 hospitals received payments to support 7,164 FTE slots	N/A
Department of Defense GME Payments Divisions of the armed forces determine their staffing needs and the number and type of residents supported.	FY2012: \$16.5 million	FY2017: 3,983 FTE residents	N/A

Data on Medicaid GME funding is limited. The Centers for Medicare & Medicaid Services (CMS) began collecting information about Medicaid GME payments made through the fee-for-service delivery system in FY2010 through the CMS-64 data. Other information about Medicaid GME payments is available from the Association of American Medical Colleges (AAMC) and the U.S. Government Accountability Office (GAO). AAMC conducts a 50-state survey about Medicaid GME payments every two to three years. According to AAMC's 2019 50-state survey, in 2018, the overall level of support for GME continued to grow, reaching \$5.58 billion. This represents a significant increase since 2009 when

Medicaid GME support totaled \$3.78 billion. However, four states reported in 2018 that their total 2018 GME payments decreased by 15% or more compared to 2015 levels.^{iv}

Private or alternative funding for GME

Examples of industry/private support outlined in a 2015 report by the AMA Council on Medical Education

The Rheumatology Research Foundation, part of the American College of Rheumatology, has administered the Amgen Fellowship Training Award, supported by Amgen Inc. since 2005. The foundation is the largest

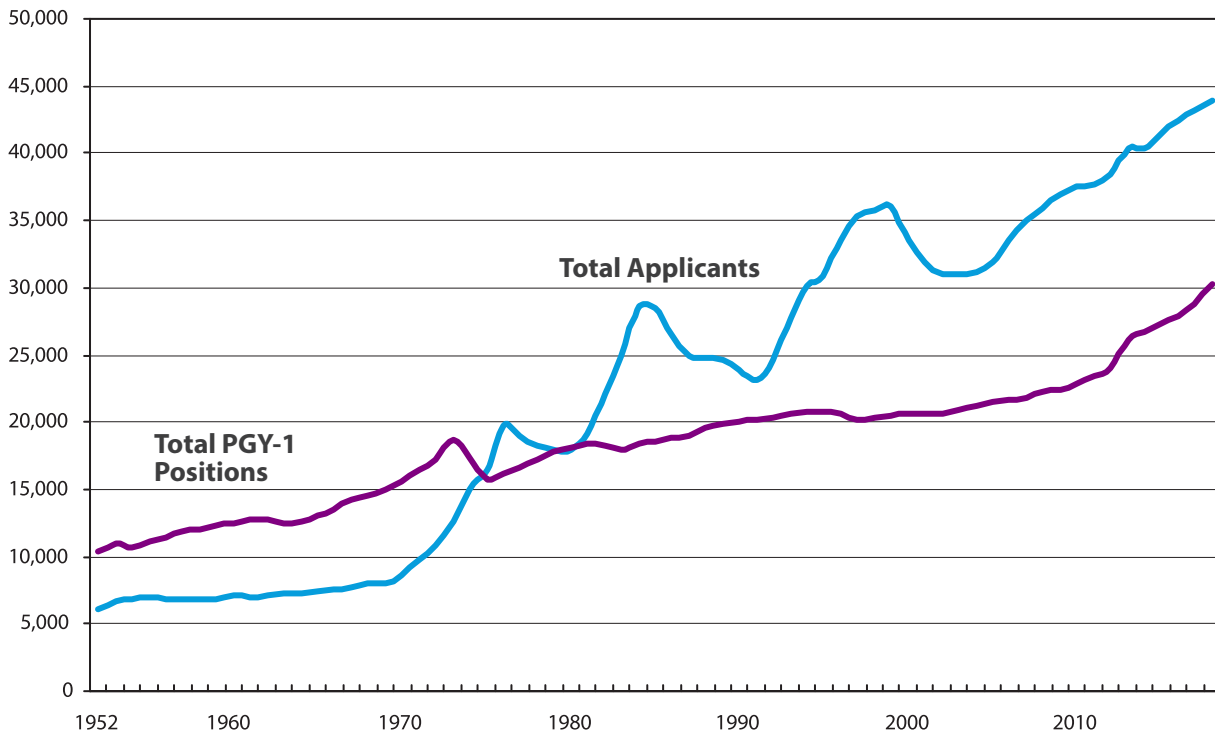
private funding source of rheumatology training and research programs in the United States. In 2014 there were 29 fellows whose funding was partially supported by a one-year, \$50,000 award to the training program. Similarly, the Neurosurgery Research and Education Foundation of the American Association of Neurological Surgeons acquires funding from several medical device companies to create \$50,000 to \$75,000 fellowships for clinical training in areas such as spinal surgery, general neurosurgery and endovascular neurosurgery. In the 2012–13 academic year the program sponsored such fellowships at 20 academic medical centers. However, GME support from private sources or pharmaceutical companies has created controversy. The American Academy of Dermatology developed a pilot program in 2006 to provide funding to dermatology programs to support 10 residents at \$60,000 per year. The program was withdrawn after the pilot, partly because of concerns that the shortage of dermatologists was not dire enough to risk an apparent conflict of interest between education and the pharmaceutical companies involved. Under the Physician Payments Sunshine Act, it is likely that a company will need to report to CMS that payments have been made to individual residents and fellows (equally divided) in a training program that it is supporting even though payments were indirect and made to the institution. A private firm that assists international medical graduates (IMGs) in finding residency positions has proposed to privately fund positions although there is no evidence to suggest this has occurred. The Menninger Clinic, when based in Topeka, Kan., created a private endowment that aided in financing GME. Other foundations exist to fund supplemental educational material that may be otherwise inaccessible. The role of foundations in GME has principally been in providing grants for research and community service. Presented with a hypothetical decrease in Medicare funding for GME, over half of designated institutional officials said they would turn to private philanthropy for assistance in funding resident positions. Nevertheless, foundations would not be a likely resource for ongoing, sustainable GME program expansion on a large scale.^v

Medicare GME caps

Congress enacted the Balanced Budget Act of 1997 (P.L. 105-33), which limits Medicare’s GME—most hospitals would receive DGME and IME support only for the number of allopathic and osteopathic full-time equivalent (FTE) residents it had in training in 1996; in other words, the number of positions Medicare supported in each hospital in 1996 was established as the upper limit in terms of the number of positions or slots that Medicare would fund in those institutions thereafter. Slots, which may be occupied by residents or fellows, do not directly correspond to a specific individual as residents or fellows may spend periods of a given year at different facilities or doing research. Residents may not be counted simultaneously for payment by two government programs. Therefore, when residents are located at different facilities, they are not counted by the sponsoring hospital.

The Medicare cap is not absolute. Medicare provides GME funding to newly constructed hospitals that introduce residency programs and to existing hospitals that did not previously sponsor residency training. Furthermore, the GME cap is not calculated and implemented until new teaching programs’ fifth year; this is meant to offer institutions time to build and scale their programs to appropriate levels.

Since the Medicare cap was enacted, some hospitals have been able to expand the number of residents they are training by using non-Medicare sources of support (e.g., hospital, state or local funds). Specifically, in the 20 years since the cap was enacted, the number of residency slots has increased by approximately 27%. Generally, these increases have been in subspecialties (i.e., for fellowship training); subspecialty services tend to generate higher revenue or impose lower cost burden on hospitals. In addition, Medicare GME slots have been redistributed since the cap was enacted. For example, the Affordable Care Act included two redistribution programs—the first redistributed unused slots, and the second continually redistributes slots from closed hospitals. However, caps on the number of resident trainees imposed by Medicare continue to further restrict the number of residency positions offered and provide the majority of teaching hospitals with little flexibility for expansion.

Figure 1: Applicants and 1st Year Positions in the Match, 1952–2018

Furthermore, based on the projected physician shortfall that is expected by 2033, the cap established in 1997 is outdated and will continue to cause stress on a health care system already beginning to show signs of strain in communities lacking sufficient numbers of physicians to care for individuals living in rural and underserved areas. By 2033, the following is projected:

- A primary care physician shortage of 21,400 and 55,200 physicians.
- A short fall across the non-primary care specialties of 33,700 and 86,700 physicians.
- A shortage of physicians in surgical specialties of 17,100 and 28,700.

Major drivers of these projected trends continue to be an aging population requiring increasingly complex care concomitant with an aging physician workforce.^{vi}

Why reform GME?

The call for GME reform is two-fold. First, Congress developed the existing GME funding scheme decades ago in 1965. Importantly, Congress intended this to be a temporary measure until a more suitable source of funding could be found. A Congressional report at that time stated: “Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of

such activities (including stipends of trainees, as well as compensation of teachers and other costs) should be borne to an appropriate extent by the hospital insurance program.” Stakeholders have since called for a restructuring of GME payment to reflect the changing health care landscape.

Second, the current system limits the number of training positions despite national and local needs. The Balanced Budget Act of 1997 used data from 1996 to set and project what was intended to be another temporary funding mechanism for GME. This funding structure has been in place ever since, limiting the number and location of training programs that can receive federal GME dollars. In addition, undergraduate medical training has increased in both size and number. U.S. medical school enrollment has increased by 31% since 2002, according to “Results of the 2018 Medical School Enrollment Survey.” Combined with first-year matriculation at osteopathic schools, medical student enrollment is now 52% higher than in 2002–03.

While the number of medical students continues to grow and the U.S. population continues to increase and grow older having more complex health needs, parallel expansion in residency training has not ensued to the same degree. Residency training positions have expanded at a rate of just 1% a year, primarily due to the congressional cap on federal funding in the Balanced Budget Act of 1997.

This issue is further exacerbated by the fact that according to data released by the Health Resources and Services Administration (HRSA) in August 2019, there are almost 77 million people living in primary medical health professional shortage areas (HPSAs). As a result, 13,991 practitioners are needed to remove the designations.

Current GME initiatives

Several stakeholders have offered potential GME reforms. While these proposals differ, the following outlines key aspects from some of the most recent proposals, and prominent organizations that are being considered as alternatives to the current funding and governance of GME.

Council on Graduate Medical Education

In the Spring of 2017, the Council on Graduate Medical Education (COGME)^{xi}, the only federal advisory panel charged with overview of GME and supporting the existing physician workforce (including rural health, rural residencies and payment models), drafted a [Report to Congress](#)^{xii} and the secretary of the HHS documenting the need for GME reform and recommending the development of a national strategic plan for GME. A number of entities have called on GME to be reformed over the years, and COGME created a chart detailing the requests and recommendations for GME reform. The COGME members outlined their desire for a “strategic plan that would work to develop a broad, coherent, and coordinated GME system, better equipped to produce a physician workforce that meets the nation’s health care needs and provides greater value for the taxpayer.”^{xiv}

GME faces an ever-growing list of persistent and deepening challenges, including the following:^{xv}

- High levels of medical student debt that may influence future career choices away from family medicine and primary care and towards higher paying specialties
- An inadequate supply of primary care physicians, general surgeons and psychiatrists compared to other medical specialists
- A rapidly evolving system of health care delivery and financing;
- Poor geographic distribution of physicians that limits access to health care for many individuals and communities in both rural and urban settings

- Under-representation of racial and ethnic minorities among medical students and, subsequently, within the physician workforce
- Learning environments and training curricula that have been outpaced by advances in medical technologies, teaching methods and health care informatics

GME shapes the physician workforce, which in turn influences the quality of and access to health care. Because a strong physician workforce is seen as a vital public good, a substantial portion of the cost of GME is supported by federal and other public funding through a complex network of funding streams. However, this funding does not cover the true cost of GME, and it lacks consistency, accountability and transparency.

As a result, COGME suggests that the GME strategic planning committee:

- Recommend methods for a 21st century curriculum consistent with society’s needs and how to achieve it, to include the sites of education and training such as inpatient and ambulatory locations
- Provide a tactical plan for developing strategies that address geographic maldistribution of medical specialists, workforce diversity and curriculum innovation consistent with securing public and private funding, and promoting physician professionalism, commitment to lifelong learning and resiliency
- Recommend public and private funding options for GME
- Solicit input from stakeholders and others to ensure comprehensive analysis, inclusiveness and awareness of potential and real conflicts of interest
- Identify informational gaps and recommend methods for obtaining data

COGME plans to hold [public meetings](#) to further discuss these important issues.^{xvi}

2014 IOM Report: “Graduate Medical Education That Meets the Nation’s Health Needs: Recommendations, Goals, and Next Steps”

In July of 2014, the National Academies of Sciences, Engineering, and Medicine (the National Academies) (formerly the Institute of Medicine or IOM) released a report entitled “Graduate Medical Education That Meets the Nation’s Health Needs: Recommendations, Goals,

and Next Steps” that has since incited serious debate as to how the current GME structure and financing should be overhauled. The major recommendations of the report are outlined in Appendix A.

The U.S. Department of Veterans Affairs and the U.S. Department of Defense

The U.S. Department of Veterans Affairs (VA) is the largest provider of health care training in the United States. However, approximately 99% of its programs are sponsored by outside medical schools or teaching hospitals. Functionally, this limits the amount of expansion that can occur in the VA system as those who train at VA locations must still be housed under a third-party GME program with full accreditation and administrative functioning. In general, each year approximately 43,000 individual physician residents receive their clinical training by rotating through about 11,000 VA-funded physician FTE residency positions at VA medical facilities.^{xviii}

The recently enacted John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018, or the “VA MISSION Act of 2018” (P.L. 115-182), included a provision to establish a new pilot program for GME in underserved areas. The AMA offered its [comments](#)^{xix} on the proposed rule implementing portions of the VA MISSION Act of 2018.

In accordance with AMA policy, we also recently [voiced](#)^{xx} our concern with the administration and Congress regarding proposals to eliminate military medical billets and GME programs throughout the Military Health System (MHS), and joined a [sign-on letter](#)^{xxi} with other health care organizations on this issue.

The president’s FY 2021 budget proposal

President Trump’s FY 2021 budget proposal recommends deep cuts to Medicare, Medicaid, GME, the National Institutes of Health (NIH), and the Health Resources and Services Administration (HRSA) Titles VII and VIII workforce programs. It is important to bear in mind that the president’s budget proposal is merely an aspirational request to Congress, the White House’s proverbial stake in the ground around which to frame future policy debates. The specific proposals therein are unlikely to be implemented. That said, the budget proposal touches on a number of issues of interest to academic medical centers that may provide some insight into upcoming policy proposals on the Hill or from CMS.

Among the president’s budget proposals of interest to the teaching hospital community are: significant GME reforms and spending cuts; proposed changes in how hospitals are paid for uncompensated care, outpatient services furnished in provider-based departments and physician-administered prescription drugs. A few of these core issues are described below.

In the midst of the COVID-19 pandemic, the administration proposes \$38.7 billion in FY 2021 for the NIH, a \$3 billion or more than 7% cut below the FY 2020 enacted program level. The president’s budget proposal would restructure GME payments to consolidate GME spending under Medicare, Medicaid and the Children’s Hospital GME program into a single grant program for teaching hospitals. All told, the proposal would result in net reductions in GME payments to hospitals of \$52.2 billion over the next ten years.

The president’s budget request proposes \$127 million in mandatory appropriations for Teaching Health Center GME (THCGME) for FY 2021, which had its funding extended by the Coronavirus Aid, Relief, and Economic Security (CARES) Act from May 22, 2020, until Nov. 30, 2020. The president’s budget proposal would eliminate the HRSA Rural Residency Program, which received \$10 million in FY 2020, and the HRSA Medical Student Education Program, which received \$50 million in FY 2020.

Federal regulatory changes related to GME

There have been several federal regulatory changes related to GME over the last few years. The AMA has provided comment on many of the proposals.

On Aug. 16, 2019, CMS released the fiscal year 2020 hospital inpatient prospective payment system (IPPS) [final rule](#).^{xxiii} The rule finalizes several proposals relating to hospital payment policy, including one that changes how a full-time equivalent (FTE) resident time may be counted when residents train at critical access hospitals (CAHs).

CMS, in an effort to remove barriers to training and to incentivize the practice of physicians in rural areas, finalized a policy in its FY 2020 IPPS rule that will allow a hospital to include in its FTE count, time spent by residents training at a CAH, so long as the hospital meets the nonprovider setting requirements located at 42 C.F.R. sections 412.105(f)(1)(ii)(E) and 413.78(g). This new policy will become effective for portions of cost reporting periods beginning Oct. 1, 2019. (See the AMA’s [comment letter](#)).^{xxiv}

On Aug. 17, 2018, CMS released the agency's fiscal year 2019 IPPS [final rule](#).^{xxv} In that rule, CMS finalized its proposal to allow new urban teaching hospitals to loan slots to other new teaching hospitals beginning July 1, 2019. CMS also granted additional flexibility, permitting a new urban teaching hospital to loan slots to existing teaching hospitals, beginning five years after its caps are set. CMS decided not to finalize its proposal to reject a cost report for lack of supporting documentation if the Intern and Resident Information System (IRIS) data do not contain the same total counts of DGME and IME FTE residents that are reported on the Medicare hospital cost report. (See the AMA's [comment letter](#)).^{xxvi}

Federal legislation for GME expansion

The AMA advocated in support of the following federal bills that were introduced during the 115th Congress (2017–2018):

- The Advancing Medical Resident Training in Community Hospitals Act of 2017 (S. 1291/H.R. 4552/H.R. 284) – The bill would have closed a loophole in GME cap-setting criteria affecting hospitals that host small numbers of residents for temporary training assignments. The AMA submitted [support letters](#) in June 2018.^{xxvii}
- The Resident Physician Shortage Act of 2017 (S. 1301/H.R. 2267) – The bill would have provided 15,000 additional Medicare-supported GME positions over five years. The AMA submitted [support letters](#) in June 2017.^{xxviii}
- The Teaching Health Centers Graduate Medical Education (THCGME) Extension Act of 2017 (S. 1754/H.R. 3394) – The bill would have reauthorized the THCGME program for an additional three years and supported program expansion to serve more rural and underserved communities. The AMA submitted [support letters](#) in September 2017.^{xxix}
- The Conrad 30 and Physician Access Reauthorization Act (S.898/H.R.2141) – The bill would have reauthorized the J-1 visa waiver program for an additional three years, protecting patient access to care in medically underserved areas across the United States. The AMA submitted a [support letter](#) in May 2017^{xxx}, in 2013^{xxxi} and in 2015^{xxxii}.
- Opioid Workforce Act of 2018 (S.2843/H.R. 5818) – The bill would have increased the number of residency positions eligible for GME under Medicare for hospitals that have addiction or pain management programs, with an aggregate increase of 1,000 residency positions over a five-year period. The AMA submitted [support letters](#) in June 2018.^{xxxiii}

The AMA advocated for the following federal bills that have been introduced during the 116th Congress (2019–2020):

- The Community and Public Health Programs Extensions Act (S. 192) – The bill would reauthorize \$310M for the National Health Service Corps, \$126M for THCGME programs, and \$4B for Community Health Centers for each fiscal year from 2019 to 2024. The AMA has submitted a [support letter](#).^{xxxiv}
- Resident Physician Shortage Reduction Act of 2019 (S.348/H.R.1763) – The bill would provide 15,000 additional Medicare-supported GME positions over five years. The AMA has submitted [support letters](#).^{xxxv}
- Opioid Workforce Act (H.R.2439) – The bill would add 1,000 Medicare-supported GME positions in addiction medicine, addiction psychiatry and pain management. The AMA has submitted a [support letter](#).^{xxxvi}
- In 2020, the AMA worked with Sen. Amy Klobuchar and a bipartisan list of other U.S. senators to shed light on the impact of the administration's negative changes in immigration policy during the COVID-19 pandemic and to promote the Conrad 30 and Physician Access Reauthorization Act (S. 948/H.R. 2895). The AMA has submitted a [support letter](#).
- Advancing Medical Resident Training in Community Hospitals Act (H.R.1358) – The bill would close a loophole in GME-setting criteria affecting hospitals that host small numbers of residents for temporary training assignments. The AMA has submitted a [support letter](#).^{xxxvii}

Additionally, a mandate in the 2018 Consolidated Appropriations Act required the GAO to examine the potential of making GME payments under Medicare for Advanced Practice Registered Nurses (APRN) and Physician Assistants (PA)—often both referred to as Advanced Practice Providers (APP)—and to identify the current, actual costs involved in training APPs. In December 2019, the GAO issued its report examining the possibility of expanding Medicare GME funding to APRNs and PAs. As noted in the report, the AMA was interviewed by the GAO for this report. The AMA extensively outlined our concerns and provided substantial research and documentation supporting our viewpoint.

Cap-flexibility

GME cap-flexibility is an emerging policy concept that calls for targeted policy efforts to provide new teaching hospitals in underserved areas flexibility and additional time in establishing Medicare-funded GME caps. The

AMA recently adopted new policy in support of cap-flex, and continues to closely work with congressional staff, as appropriate, to further cap-flex policy. In addition, the AMA submitted letters in support of cap-flex to the administration in 2017^{x1} and again in 2019.^{x1i}

The AMA also has voiced support for H.R. 6090/S. 3390, “Physician Shortage GME Cap Flex Act of 2020” that would provide a new building period with respect to the cap on full-time equivalent residents for purposes of payment for graduate medical education costs under the Medicare program for certain hospitals that have established a shortage specialty program.

“Reimagining Residency” initiative

In 2013, the AMA instituted the “Accelerating Change in Medical Education” initiative by making grants to medical schools to support undergraduate medical education innovation. The “Reimagining Residency” initiative is the next phase in this effort. The aim of this five-year, \$15-million grant program is to significantly improve GME through bold, rigorously evaluated innovations that align residency training with the needs of patients, communities and the rapidly changing health care environment. Funding will be provided to U.S. medical schools, GME programs, GME sponsoring institutions, health systems and other organizations associated with GME to support bold and innovative projects that promote systemic change in graduate medical education. The awardees of the \$15-million Reimagining Residency grant program have been named; and the grant teams will join the Accelerating Change in Medical Education Consortium, which consists of 37 medical schools working to transform medical education across the continuum.

SaveGME.org

The AMA created the [SaveGME.org](https://www.savegme.org) webpage in 2013 as a grassroots advocacy platform that medical students and residents could use to apply pressure to lawmakers in favor of preserving essential funding for GME. In 2017, the [SaveGME.org](https://www.savegme.org) website was updated to include public-facing messaging and educational materials. To date, more than 3,000 medical students and residents have taken action via [SaveGME.org](https://www.savegme.org) to urge their members of Congress not to make cuts to GME.

2020 Medical Student Advocacy & Region Conference (MARC)

Each year, approximately 400 medical students participate in the [MARC](https://www.marcgme.org)^{x1iii} and advocate for increased GME funding. Medical students learn about relevant

legislation and lobby their members of Congress on Capitol Hill in Washington, D.C.

Legal update

On June 29, 2018, the U.S. Court of Appeals for the DC Circuit invalidated a CMS regulatory interpretation that prevented hospitals from correcting old cost-reporting errors that continue to impact current and future Medicare reimbursements. In *Saint Francis Medical Center v. Azar*,^{x1iv} the court sided with a group of hospitals challenging factual determinations, derived from 1981 cost-reporting data, that were used to determine base rates known as standardized amounts. The hospitals’ standardized amounts were calculated in 1983, but permanently affect the formula used to determine the hospitals’ prospective payment amounts. At issue in the case was whether CMS’s “predicate facts” rule—factual determinations that are relevant to the payment year at issue, but that were made in earlier years—barred the hospitals from appealing the determinations used to calculate their standardized amounts. The DC Circuit held that CMS’s predicate facts rule applies only in the “reopening” context and does not prohibit administrative appeals of current cost reports for the purpose of prospectively correcting errors in long-settled base-year determinations.

This decision has significant implications for GME reimbursement because it means that providers may challenge, in current and future appeals, prior incorrect “base-year” determinations (e.g., those based on erroneous data) that are used to determine GME reimbursement on a go-forward basis. Two examples of such determinations include (i) the number of resident FTEs counted during a hospital’s three- or five-year cap-building window that are used to determine the hospital’s permanent GME FTE caps, and (ii) the calculation of costs used to determine a hospital’s per resident amount (PRA).

State initiatives

The majority of GME funding at the state level comes from Medicaid. According to the AAMC Medicaid GME Survey, in 2018 42 states plus D.C. made GME payments under their Medicaid program. Additional state funding comes from a variety of programs aimed at encouraging physicians to practice in certain states, practice in certain specialties such as primary care, or practice in rural and underserved areas of the state. Following is a sample of such efforts.

Regional medical education: The WWAMI experiment

Regional medical education is a concept catching on in states working to not only increase the number of medical students and residents in the state, but also to use physician training to expand access to care in rural and underserved areas. In the early 1970s, the University of Washington took on a bold challenge to train and prepare physicians to care for patients and communities throughout the states of Washington, Alaska*, Montana and Idaho (Wyoming joined in 1996). Today, this regional medical education program known as WWAMI (an acronym representing the states it serves) is heralded as one of the most innovative medical education and training programs in the country. (NOTE: *In a controversial move, Alaska's Gov. Dunleavy put all payments for WWAMI on hold in the 2020 budget, threatening future participation of Alaska's medical students and residents currently in the program.)

The program has five primary goals:

- Provide publicly supported medical education
- Increase the number of primary-care physicians
- Provide community-based medical education
- Expand graduate medical education (residency training) and continuing medical education
- Provide all of this in a cost-effective manner

Under this regional medical education model, each participating state partners with the UW School of Medicine (UWSOM) to educate a fixed number of medical students from and for their state. Each year, approximately 65 third-year medical students choose WWAMI sites for a portion or all of their basic medicine clerkship. In addition, about 35 fourth-year students travel each year to WWAMI sites for advanced primary care clerkships.

For the first year of medical school, students study at their home state university (University of Washington, University of Wyoming, University of Alaska-Anchorage, Montana State University, or University of Idaho). Second-year students from home state universities then come to the UWSOM in Seattle or Spokane for their entire second year. During the third and fourth years of medical school, students complete clinical rotations in a variety of sites and environments within the five-state region to learn and experience very different facets of medicine. For example, one month might be spent in a remote community near Nome, Alaska, another in a migrant community near Yakima, Wash., and another in a Level I trauma center in Seattle. The goal is to

provide a rich array of clinical experiences in a variety of settings, mentored by community-based clinical faculty who volunteer their time to educate the physicians in training.

Medical residents also participate in the WWAMI program. The Department of Medicine sponsors Boise Internal Medicine with eight categorical residents per year, and another 20 travel to WWAMI sites for elective block rotations. In addition to Boise, WWAMI sites include Wenatchee and Toppenish, Wash.; Billings, Missoula, Dillon, Livingston, and Sidney, Mont.; and Soldotna, Alaska. Residents work in a number of settings in these communities, from solo practitioner offices to large clinics and hospitals. The rural rotations are highly rated and always in demand.

A variety of programs are available in communities throughout the five-state region that provide not only an educational experience for medical students, but also supports community efforts through volunteerism. These include:

- WWAMI Rural Integrated Training Experience (WRITE): A six-month experience in a rural setting in which students complete clinical training working closely with community preceptors (clinical instructors)
- Rural/Underserved Opportunities Program (R/UOP): Four-week preceptorships (mentorships) available with practicing physicians in rural and urban underserved communities held over the summer between a student's first and second year
- Targeted Rural Underserved Track (TRUST): Longitudinal experience with a single rural community over a student's entire medical school career, including completing both WRITE and R/UOP and returning regularly to learn about and work in the community

WWAMI-participating schools of medicine are central to a network of programs designed to alleviate the shortages of health care programs in rural and underserved urban areas. These programs include:

- Area Health Education Center Network (AHEC): A program that works to improve the diversity, distribution and quality of the health workforce in the WWAMI region, partnering with communities to promote health career pathways, create educational opportunities for students from junior high school through professional and post-graduate training, and support health care providers caring for

underserved populations.

- The WWAMI Center for Health Workforce Studies conducts studies in the WWAMI region that can inform policy and advance workforce needs to address state health care workforce issues.
- The WWAMI Rural Health Research Center focuses on policy affecting rural and underserved areas.

A majority of the students training in the program choose to remain and practice medicine within the five-state region, and over half choose careers in primary care, helping to stem the shortage of primary care physicians, especially in rural areas. More than 20% of the population in the five Pacific Northwest states lives in rural and largely underserved communities.

Expansion of residency positions through alternative financing

California

Physicians for Healthy California (formerly CMA Foundation), provides funding to primary care and emergency medicine residency programs aimed at those serving medically underserved areas and populations.

In 2014, California's Gov. Brown approved a budget including \$7 million in new funding for primary care residency positions. Three million dollars will be applied to expand the Song-Brown Programs to all primary care specialties (family medicine, internal medicine, obstetrics-gynecology and pediatrics). The additional \$4 million will fund residency programs that wish to expand and train more residents. The budget act requires priority be given to programs that have graduates of California-based medical schools, reflecting the overwhelming data that physicians who obtain their medical degree and complete training in California are very likely to practice in the state. The AMA strongly encouraged Gov. Brown to approve this important funding.

In 2016, California committed \$100 million over three years to the Song-Brown Healthcare Workforce Training Programs, including funding for primary care residency positions.

Georgia

Beginning in FY 2013, dollar-for-dollar funds are available from the state for hospitals to start residency programs. The goals of this funding stream include creating 400 new positions in hospitals that previously had no programs, ensuring some concentration in

primary care specialties and general surgery, and developing residencies in geographically underserved parts of the state. Currently four hospitals are developing programs with the potential of creating upwards of 267 positions. Funding is only for the process of creating a program, thus covering accreditation costs, hiring staff, purchasing new equipment and so forth. Once a hospital has residents enrolled and is receiving Medicare funds, the state program ceases to support the hospital.

In 2014, Georgia adopted legislation (S.B. 391) to provide a tax deduction for primary care community-based faculty (CBF) precepting third- and fourth-year medical students, physician assistant (PA) students, and nurse practitioner (NP) students. The impetus behind this new law was a trend of off-shore and out-of-state medical schools using Georgia CBF. The new law is intended to provide an incentive to Georgia CBF to serve as preceptors for Georgia medical, PA and NP students—an incentive that other states may want to offer as well. In November 2014, the AMA Board of Trustees approved model state legislation, inspired by Georgia's efforts, that provides a tax credit or tax deduction for community-based faculty preceptors. In 2019, Gov. Kemp signed into law H.B. 287, which repealed the tax deduction program and replaced it with a tax credit program, allowing eligible community-based preceptors who provide uncompensated preceptorship training to medical students, advanced practice registered nurses or physician assistants. Physicians can receive up to \$8,500 in tax credits for 10 rotations per calendar year.

Hawaii

In 2017 the state legislature and governor approved a \$1.8 million appropriation for the Primary Care Training Program at Hilo Medical Center, which will support several disciplines, including four new family medicine residents a year for three years.

Idaho

Several years ago, the state legislature funded a new family medicine program. In addition, the Family Medicine Residency of Idaho received, from the Blue Cross Foundation of Idaho, \$100,000 per year to support rural rotations for residents.

Indiana

In 2015, then-Gov. Mike Pence signed H.B. 1323 into law. The law establishes the medical residency education fund for the purpose of expanding medical education in Indiana by funding new residency program slots at

licensed hospitals. In addition, the new law established a Graduate Medical Education Board under the state Commission for Higher Education in order to: (1) provide funding for residents not funded by the federal Centers for Medicare & Medicaid Services; (2) provide technical assistance for entities that wish to establish a residency program; (3) fund infrastructure costs for an expansion of graduate medical education; and (4) provide startup funding for entities delivering medical residency education.

Under the new law, a recipient of a medical education residence grant or money from the graduate medical education fund must agree to provide matching funds equal to at least 25% of the money provided. In addition, the law required the board to prepare and submit a report to the general assembly before Nov. 1, 2016, concerning recommendations for the expansion of graduate medical education in Indiana. The resultant proposed model was a Primary Care GME Consortium, an independent 501(c)(3) not-for-profit corporation, through which hospitals and other organizations partner to develop residency programs and act as the vehicle to expand physician training. According to the board, consortium models increase opportunities to attract funding from federal, state and alternative funders. The board's work is ongoing.

Maryland

The state boasts an all-payer system to fund GME, the only one in the nation, which is managed through the Health Service Cost Review Commission (HSCRC). However, in recent years no additional funding has been requested explicitly for new programs or positions. The HSCRC has no role in influencing the number or specialty of residents in training.

Minnesota

Clinical training sites consisting of a variety of health professions are supported through the Medical Education and Research Costs program; these grants are provided through state and federal medical assistance funds and cigarette tax proceeds. The FY 2014–15 base budget is \$44.3 million. New in FY 2013 was a \$1 million per year grant program for family medicine residency programs outside the seven-county metropolitan area. To be eligible, programs must demonstrate that within the three most recent years at least 25% of graduates practice in Minnesota communities outside the metropolitan area.

Montana

In 2013, the legislature added \$200,000 to the state's appropriation for GME and approved an additional \$240,000 to support rural rotations for residents.

North Carolina

The Blue Cross Blue Shield of North Carolina Foundation is providing partial funding to establish the University of North Carolina Family Medicine's Underserved Residency Track, which will train two residents per year for three years in underserved communities.

North Dakota

The Health Care Workforce Initiative, funded by state government, will allow the University of North Dakota School of Medicine and Health Sciences to expand with the expectation that by the 2017–2018 academic year, there will be 64 additional medical students (16 per year), 90 health sciences students (30 per year) and 51 residents (post-MD degree trainees, with 17 per year added). This initiative is expected to retain more graduates for practice in North Dakota.

Oklahoma

In 2012, the state legislature allocated \$3 million to establish new primary care residency programs in underserved areas administered by the Oklahoma State University College of Osteopathic Medicine or the University of Oklahoma College of Medicine with the expectation that the programs become funded by Medicare. Funds from the Tobacco Settlement Endowment have also been tapped to help fund medical residency programs. In 2015 a six-year \$3.8 million grant was awarded to Oklahoma State University Medical Authority, resulting in 54 residency slots. In 2019 \$2.3 million was granted to fund two hospital residency programs.

Wisconsin

New funding for several new GME initiatives was recently approved, including \$1.7 million to increase the Medical College of Wisconsin's (MCW) family medicine programs by 12 new positions, primarily in underserved areas of Milwaukee. The state also made a start-up investment for MCW's planned new programs in northeastern and central Wisconsin. In addition, the Wisconsin Department of Health Services will be supporting 10 new residency slots in existing programs, targeting specialties in need (family medicine, general internal medicine, general surgery, pediatrics and psychiatry) and rural locations. Programs can apply for

expansion of up to three positions (three in one year, or one in each of three years). Programs in bordering states are eligible if they have a substantial presence in Wisconsin (e.g., rotations in the state, graduates who practice in Wisconsin). The state is seeking matching Medicaid funds, which would allow for doubling the number of new positions. Finally, the state will assist rural hospitals or consortia of rural hospitals to develop new residency programs with up to \$1.75 million available for three years, limited to the same specialties noted above.

Loan forgiveness programs

At least 30 states use, or plan to use, some kind of loan forgiveness/repayment program to encourage physicians to practice in primary care and/or underserved areas. There generally are stipulations as to how long the service must be, and maximum dollar amounts allowed. Following is a sample of some of these programs.

California

Steven M. Thompson Loan Repayment Program, created by the California Medical Association, provides up to \$105,000 in grants to physicians in exchange for a three-year commitment to work in a medically underserved area.

The CalHealthCares Program, created through Physicians for Healthy California (formerly CMA Foundation), administers a loan repayment program for eligible physicians and dentists. Awardees must maintain a patient caseload of 30% or more Medi-Cal beneficiaries and may receive up to \$300,000 in loan repayment in exchange for a five-year service obligation. The program is funded with revenue appropriated from Proposition 56.

In 2013, California passed S.B. 21, which requests that the newly accredited University of California Riverside School of Medicine identify eligible residents and assist them with applying to physician retention programs, such as loan repayment programs, that require service to an underserved or rural area of the state in exchange for debt assistance.

Hawaii

In 2017, Hawaii passed H.B. 916, which appropriated \$250,000 to the department of health for 2017–2018 and 2018–2019 to provide loan repayment for physicians, physician assistants, psychologists and nurse practitioners who agree to work in a federally designated health professional shortage area or an area of Hawaii found to be underserved. The expenditure is

to be undertaken in coordination with the John A. Burns School of Medicine of the University of Hawaii at Manoa.

Iowa

The Primary Care Recruitment and Retention Endeavor (PRIMECARRE) through the Iowa Department of Public Health offers two-year grants (\$50,000 for physicians) awarded to primary care health care practitioners in exchange for a two-year commitment to work in a public or non-profit site located in a health professional shortage area (HPSA).

New Mexico

New Mexico's Health Professional Loan Repayment Program is a competitive program available to a variety of health professionals, including primary care physicians. Applicants must agree to practice for two years in a designated medical shortage area in New Mexico.

New York

Doctors Across New York, a program through New York's Department of Health, helps train and place physicians in underserved areas. The program funds both the Doctors Across New York Physician Loan Repayment Program and Physician Practice Support Program. Awards can be given to individual physicians or health care facilities. All awards require a three-year commitment and awardees can receive up to \$120,000.

A second program, Regents Physician Loan Forgiveness Program through the New York State Education Department, offers a loan repayment program of up to \$10,000 each year for two years for physicians in physician shortage areas.

Oklahoma

Funds from Oklahoma's Tobacco Settlement Endowment Trust are used to provide grants to the Physician Manpower Training Commission, which grants up to \$160,000 in loan repayment for physicians in the program who practice up to four years in a medical underserved or rural area.

Tennessee

The Tennessee State Loan Repayment Program provides \$50,000 per year for a two-year commitment, and up to \$20,000 per year after that, in exchange for service in a HPSA, federally qualified health center or rural health center.

Texas

Physician Education Loan Repayment Program (PELRP), administered by the Texas Higher Education Coordinating Board, provides loan repayment to physicians in exchange for commitment to practice in a Health Professional Shortage Area for at least four years and agree to provide care to CHIP and Medicaid patients.

International medical graduates

J-1 visas

The Exchange Visitor (J) non-immigrant visa category is for individuals approved to participate in work- and study-based exchange visitor programs. J-1 status physicians are participants in the U.S. Department of State (DoS) Exchange Visitor Program. The primary goals of the Exchange Visitor Program are to allow participants the opportunity to engage broadly with Americans, share their culture, strengthen their English language abilities, and learn new skills or build skills that will help them in future careers. The first step in pursuing an exchange visitor visa is to apply through a designated sponsoring organization. In the U.S., physicians may be sponsored for J-1 status by the Educational Commission for Foreign Medical Graduates (ECFMG) for participation in accredited clinical programs or directly associated fellowship programs. These sponsored physicians have J-1 “alien physician” status and pursue graduate medical education or training at a U.S. accredited school of medicine or scientific institution, or pursue programs involving observation, consultation, teaching or research.

Currently, resident physicians from other countries working in the U.S. on J-1 visas are required to return to their home country after their residency has ended for two years before they can apply for another visa or green card. The Conrad 30 program allows these physicians to remain in the U.S. without having to return home if they agree to practice in an underserved area for three years. For the 116th Congress, the AMA supported^{xiv} and helped draft the Bipartisan (H.R.2895/S.948) Conrad State 30 and Physician Access Reauthorization Act. This bill would reauthorize the J-1 visa waiver program for an additional three years and make improvements to the program by requiring more transparency in employment contract terms. The legislation would also address the current physician green card backlog exacerbated by the statutory per-country cap for employment-based green cards. Physicians who practice in underserved areas for five years would be eligible to receive priority access within the green card system. The AMA has consistently supported the Conrad 30 program in previous congressional sessions (2017,^{xlv} 2015,^{xlvii} 2013,^{xlviii} 2012^{xlvix}).

According to the U.S. Department of State, for calendar year (CY) 2018, there were 2,738 new J-1 physicians participating in the exchange program. For CY 2018 the top three “sending countries” for J-1 physicians were: Canada 689; India 489; and Pakistan 248. The top three “receiving U.S. states” for J-1 physicians were: New York 556; Michigan 182; and Texas 163.

H-1B visas

Each year, thousands of medical students and graduates all over the world receive offers to enter GME programs in the United States. IMGs who are not U.S. citizens or permanent residents and seek entry into U.S. GME programs, must obtain a visa that permits clinical training to provide medical services. Most enter the U.S. on a J-1 Exchange Visitor visa or an H-1B visa (temporary worker in a “specialty occupation”). The intent is that the non-U.S. citizen IMGs seeking to obtain an H-1B visa each year work in rural and underserved areas of this country to provide care to some of our most vulnerable citizens. An analysis of 2016 data from the U.S. Department of Labor Office of Foreign Labor Certification (OFLC) reveals that U.S. employers were certified to fill approximately 10,500 H-1B physician positions nationwide.^{xi} In 2016, of the 897,783 practicing physicians in the United States, 206,030 (23 percent) did not graduate from a U.S. or Canadian medical school. The chart below, developed by ECFMG, highlights the IMGs working with ECFMG each year to obtain clinical training in the U.S.^{xii}

ECFMG® FACT CARD

Summary Data Related to ECFMG® Certification

	2017	2018	2019
National Resident Matching Program®			
Total IMG Participants	12,355[†]	12,144[†]	11,950[†]
Number Matched	6,591	6,862	7,025
Percent Matched	53%	57%	59%
Non-US Citizen IMG Participants	7,284	7,067	6,869
Number Matched	3,814	3,962	4,028
Percent Matched	52%	56%	59%
US Citizen IMG Participants	5,069	5,075	5,080
Number Matched	2,777	2,900	2,997
Percent Matched	55%	57%	59%

ECFMG Exchange Visitor Sponsorship

Physicians Approved for J-1 Visa Sponsorship (2017) 10,953
Physicians Approved for J-1 Visa Sponsorship (2018) 11,385

Appendix A: Recommendations from the 2014 IOM Report – “Graduate Medical Education That Meets the Nation’s Health Needs”

GOALS FOR FUTURE GME FUNDING	RECOMMENDED NEXT STEPS
<p>Goal #1 Encourage production of a physician workforce better prepared to work in, help lead, and continually improve an evolving health care delivery system that can provide better individual care, better population health, and lower cost.</p>	<ol style="list-style-type: none"> 1. Amend Medicare statute to allow for a new Medicare GME performance-based payment system with incentives for innovation in the content and financing of GME in accord with local, regional, and national health care workforce priorities. 2. Create a high-level GME policy and financing infrastructure within the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) with responsibility for federal GME policy, including development, testing, and implementation of new payment methods. <p><i>See Recommendations 1, 2, 3, and 4.</i></p>
<p>Goal #2 Encourage innovation in the structures, locations, and designs of GME programs to better achieve Goal #1.</p>	<ol style="list-style-type: none"> 1. Distribute Medicare GME funds to the organizations that sponsor residency programs via a national per-resident amount (geographically adjusted). 2. Create one unified GME fund to replace the separate Indirect Medical Education and Direct Graduate Medical Education funding streams. 3. Conduct demonstrations to identify feasible and effective performance-based payment methodologies. 4. Delink Medicare GME payments from teaching institutions’ Medicare patient volume. <p><i>See Recommendations 3 and 4.</i></p>
<p>Goal #3 Provide transparency and accountability of GME programs, with respect to the stewardship of public funding and the achievement of GME goals.</p>	<ol style="list-style-type: none"> 1. Require standardized reports from sponsoring organizations as a condition for receiving Medicare GME funding. 2. Develop a minimum dataset for sponsors’ reports to facilitate performance measurement, program evaluation, and public reporting. 3. Develop performance measures to monitor program outcomes with respect to those goals. 4. Provide easy access to GME reports for the public, stakeholders, researchers, and others. <p><i>See Recommendation 2.</i></p>
<p>Goal #4 Clarify and strengthen public policy planning and oversight of GME with respect to the use of public funds and the achievement of goals for the investment of those funds.</p>	<ol style="list-style-type: none"> 1. Create a high-level GME policy and financing infrastructure within HHS and CMS with responsibility for federal GME policy, including development, testing, and implementation of new payment methods. <p><i>See Recommendation 2.</i></p>
<p>Goal #5 Ensure rational, efficient, and effective use of public funds for GME in order to maximize the value of this public investment.</p>	<ol style="list-style-type: none"> 1. Use a portion of current Medicare GME funds to fund the new infrastructure, developmental activities, new training slots (where needed), and program evaluation. <p><i>See Recommendations 1, 2, 3, and 4.</i></p>
<p>Goal #6 Mitigate unwanted and unintended negative effects of planned transitions in GME funding methods.</p>	<ol style="list-style-type: none"> 1. The GME Policy Council should develop a strategic plan—in consultation with the CMS GME Center and GME stakeholders—that allows for a careful phase-in of the reforms. 2. The Council should ensure that its blueprint for the transition includes a rigorous strategy for evaluating its impact and making adjustments as needed. <p><i>See Recommendation 2.</i></p>

COVID-19 and its impact on GME

According to the [Centers for Disease Control and Prevention](#)¹ⁱⁱⁱ (CDC), COVID-19 is a virus that has been identified as the cause of an outbreak of respiratory illness. The spread of the disease grew into a pandemic and killed over 100,000 people. As a result of COVID-19, GMEs have had to alter their medical education and residencies. For students, many classes were switched to online learning, clinical rotations were cancelled, and testing requirements were changed. Some medical schools even graduated their fourth-year students early to deploy them to help care for patients during the public health crisis. As such, many residents and medical students played a critical role in responding to COVID-19. These GMEs have provided care to patients on the frontlines, been redeployed from their primary training programs, and have put their lives on the line treating some of the sickest patients, many without appropriate protective equipment.

Temporary federal regulatory changes related to GME and the public health emergency

There have been a number of temporary federal regulatory changes related to the public health emergency in 2020. However, there have been a few changes that specifically impact GME.

On March 2020, CMS announced waivers and flexible policies that specifically address the needs of teaching hospitals. The CMS guidance document entitled “Teaching Hospitals, Teaching Physicians and Medical Residents: CMS Flexibilities to Fight COVID-19” addresses teaching physician supervision issues and resident FTE time-counting rules that apply during the period of the section 1135 emergency, among many other regulatory waivers.

On April 6, 2020, CMS issued an [Interim Final Rule](#)^{1v} with comment period that provides policy and regulatory revisions in response to the COVID-19 public health emergency. Some of these provisions will be particularly beneficial to residents, including changes that allow teaching physicians to provide services with medical residents virtually through audio/video real-time communications technology. Additionally, residents can now perform their duties in alternate locations, including their homes or a patient’s home so long as they meet appropriate physician supervision requirements, and moonlighting can be considered as a separately billable service in a hospital in which a resident has their training program.

On April 30, 2020, CMS issued a second [Interim Final Rule](#)^{1vi} with comment period that gives providers

additional regulatory flexibilities during the current public health emergency. Among these regulatory changes are a few provisions that will be especially beneficial for GME students and residents during this time. Firstly, IME payments will not be affected by the number of available beds in a hospital and the available bed count will be “considered to be the same as it was on the day before the emergency was declared.” Additionally, CMS is allowing teaching hospitals to claim the FTE time of residents at other hospitals on its Medicare hospital cost report during the declared emergency under certain circumstances. Moreover, teaching physician supervision rules have changed and now the list of services that may be provided through the primary care exception have been expanded, and teaching physicians may “review the services provided with the resident, during or immediately after the visit, remotely through virtual means via audio/video real time communications technology.”

On May 11, 2020, CMS released the FY 2021 Inpatient Prospective Payment Services (IPPS) Proposed Rule^{1vii}, which includes proposed changes related to closing hospitals and closing residency programs. CMS’ proposals focus on how “displaced residents” are defined for purposes of determining whether the closing hospital or program can voluntarily transfer temporary cap slots to other hospitals that agree to train the residents for the remainder of their programs. The proposed changes will take effect Oct. 1, 2020. On July 9, 2020, the AMA [commented](#) on the IPPS Proposed Rule (CMS-1735-P). The AMA supports the new definition of “displaced resident” and believes that this will help to ensure that all residents are included and supported during future hospital and program closures.

On May 15, 2020, CMS issued guidance^{1viii} offering providers flexibility in completing physician time studies. For the duration of the public health emergency, providers may use the following time study options:

- “One-week time study every six months (two weeks per year)”
- “Time studies completed in the cost report period prior to Jan. 27, the PHE effective date (e.g., hospital with a July 1, 2019–June 30, 2020 cost reporting period could use the time studies collected July 1, 2019 through Jan. 26, 2020; no time studies needed for Jan. 27, 2020–June 30, 2020)”
- “Time studies from the same period in CY 2019 (e.g., if unable to complete time studies during February through July 2020, use time studies completed February through July 2019)”

On May 21, 2020, CMS issued new guidance^{1ix} providing that, during the public health emergency, teaching hospitals have until Oct. 1, 2020, to submit new or amended Medicare GME-affiliated group agreements. It is our understanding that CMS has since rescinded this guidance for technical reasons but plans to issue a formal waiver in the near future extending the submission deadline to Oct. 1.

On June 1, 2020, the AMA [commented](#) on CMS-1744-IFC; Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency. In this letter, our AMA endorsed the use of innovative models of clinical and educational work-hour requirements and direct resident physician supervision via real-time, interactive audio and video technology to optimize patient safety and competency-based learning opportunities during the COVID-19 pandemic. The AMA further supported the limits on direct supervision by interactive telecommunications technology to exclude high-risk, surgical, interventional and other complex procedures, including endoscopies and anesthesia. Moreover, the AMA supported the expansion of the primary care exception to include all levels of office and outpatient evaluation and management (E/M) codes.

Federal legislation that aids and expands GME

The AMA advocated for, or advised on, the following federal bills that have been introduced during the 116th Congress (2019–2020):

- Health Heroes Act (H.R. 6650) – The bill would bolster the National Health Service Corps (NHSC) by providing an additional \$25 billion for both the loan repayment and scholarship programs to increase the number of medical professionals in underserved communities in fiscal year 2020. In addition, the proposal increases the mandatory NHSC funding level from \$310M to \$690M for fiscal years 2021–2026 to increase scholarship and loan forgiveness awards to meet the nation's health needs. The AMA provided technical assistance in the creation of this bill.
- Rural America Health Corps Act (S.2406) – The bill would build upon the existing NHSC model by providing up to five years of loan forgiveness, compared to the standard two-year period, to help pay down medical school debt. The AMA provided technical assistance in the creation of this bill.
- Student Loan Forgiveness for Frontline Health Workers Act (H.R. 6720) – The bill would provide total student loan forgiveness for physicians,

residents and medical students that aid in responding to the COVID-19 crisis. The AMA submitted a [support letter](#).^{1x}

- Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (S. 3548 and H.R. 784) – The bill was passed into law and provides a coronavirus relief fund package that contains provisions to aid medical students, including deferment of student loan payments and interest until September 2020, increased federal student aid and federal work study flexibility. For more information see Sections 3503–3513 of the CARES Act or the [AMA CARES Act Summary](#).^{1xi}
- Health and Economic Recovery Omnibus Emergency Solutions Act (HEROES Act) (H.R. 6800) – The bill is the next proposed coronavirus relief fund package and includes provisions to aid medical students and education, including extending deferment of student loan payments and interest until September 2021, expanding public service loan forgiveness to some physicians, and increasing grants to schools of medicine in rural and underserved communities. Additionally, the HEROES Act contains many of our IMG advocacy requests including authorization of the Conrad 30 program, expedited visa processing, and employment authorization cards for IMGs. For more information see Sections 150113–150121 and 191201 and 191204 of the HEROES Act or the [AMA HEROES Act Summary](#).^{1xii}
- Healthcare Workforce Resilience Act (H.R. 6788 and S. 3599) – The bill would allow the U.S. to recapture 15,000 unused employment-based physician immigrant visas from prior fiscal years that would help enable our U.S. physicians to have the support they need and our U.S. patients to have the care they deserve. The AMA sent support letters to the [House of Representatives](#)^{1xiii} and the Senate.^{1xiv}

GME resource guides

In response to the changes brought about by COVID-19 the AMA released [GME resource guides](#)^{1xv} that address some of the benefits that are currently available for residents and medical students, ranging from loan relief, to additional grants, to new policies that help make it easier to practice as a resident during this challenging time. The information in the resource [guides](#)^{1xvi} also highlight some of the helpful provisions that the AMA successfully advocated for in the CARES Act, including the deferment of student loan payments and interest, increased volunteer liability protections and federal work study flexibility.

International medical graduates and COVID-19

Visa processing, allocation and extensions

Due to COVID-19, U.S. Citizenship and Immigration Services (USCIS) slowed its processing of visas and suspended premium processing. As such, international medical graduate (IMG) physicians were concerned about being able to obtain visas in a timely manner. In response, on March 24, 2020, the AMA sent a [letter](#)^{1xvii} to USCIS urging USCIS to reconsider the suspension and, instead, expand premium processing for H-1B visas.

Moreover, embassies and consulates stopped processing visas, including J-1 physician visas. As such, J-1 physicians were concerned that they would not be able to obtain or maintain a valid visa. Additionally, due to visa restrictions, J-1 physicians were concerned about being able to continue their training during the pandemic. In order to aid J-1 physicians, the AMA sent a [letter](#)^{1xviii} to the U.S. Department of State (DoS) and the U.S. Department of Homeland Security (DHS) requesting that they open visa processing at embassies and consulates for physicians seeking to enter the U.S. to join residency programs on July 1, 2020. Additionally, the AMA requested that J-1 physicians be allowed to engage in extended training activities and asked for confirmation concerning J-1 physician redeployment to new rotations to respond to the pandemic. As a result of AMA advocacy, in concert with ECFMG, the DoS agreed to begin [processing visa applications](#)^{1xix} for foreign-born medical professionals and announced that J-1 physicians may consult with their program sponsor to extend their programs in the U.S., and confirmed that J-1 physicians can engage in revised clinical training rotations/ assignments in keeping with the ACGME's "[Response to Pandemic Crisis](#)."^{1xx}

IMG physicians were also concerned about alterations in work schedules and the visa consequences of being laid-off due to COVID-19. To help ease these concerns, on April 14, 2020, the AMA sent a [letter](#)^{1xxi} urging USCIS to recognize COVID-19 as an extraordinary circumstance beyond the control of the non-U.S. citizen IMG applicant or their employer and, consequently, expedite approvals of extensions and changes of status for non-U.S. citizen IMGs practicing, or otherwise lawfully present, in the U.S. In addition, the AMA urged the administration to extend the current 60-day maximum grace period to a 180-day grace period to allow any non-U.S. citizen IMG who has been furloughed or laid-off as a result of the pandemic to remain in the U.S. and find new employment. Moreover, the AMA asked USCIS to protect

the spouses and dependent children of H-1B physicians by automatically granting a one-year extension of their H-4 visas. Due in part to the advocacy efforts of the AMA, USCIS [announced](#)^{1xxii} that it is temporarily waiving certain immigration consequences for failing to meet the full-time work requirement.

Labor condition applications

Labor condition application restrictions have made it difficult for IMGs to practice in areas where they are most needed during the pandemic. As such, on April 3, 2020, the AMA wrote a [letter](#)^{1xxiii} to Vice President Pence and USCIS urging the administration to permit IMG physicians currently practicing in the U.S. with an active license and an approved immigrant petition to apply and quickly receive authorization to work at multiple locations and facilities with a broader range of medical services for the duration of the COVID-19 pandemic. The AMA also urged the administration to expedite work permits and renewal applications for all IMG physicians who are beginning their residency or a fellowship or are currently in training. Due in part to the advocacy efforts of the AMA, USCIS [announced](#)^{1xxiv} that IMGs can deliver telehealth services during the public health emergency without having to apply for a new or amended labor condition application.

Presidential proclamation

On April 22, 2020, President Trump made a [proclamation](#)^{1xxv} entitled "Suspending Entry of Immigrants Who Present Risk to the U.S. Labor Market During the Economic Recovery Following the COVID19 Outbreak." This proclamation created a partial immigration ban and contained a provision that stated that the president would review the proclamation and determine if additional measures, including limiting or restricting non-immigrant visas, needed to be included. In response, the AMA sent a [letter](#)^{1xxvi} to Vice President Pence urging the administration to allow J-1, H-1B and O-1 IMGs to be exempt from any future immigration bans or limitations.

IMG resource guide

Due to the uncertainty that IMGs are experiencing during this time, the AMA created an IMG resource guide entitled "[FAQs: Guidance for international medical graduates during COVID-19](#)."^{1xxvii} This guide answers some of the most pressing questions that IMGs have surrounding their ability to practice, their visas and resources that are available for IMGs.

Appendix B: Relevant AMA policy

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

Our AMA will work with: (1) the federal government, including the Centers for Medicare and Medicaid Services, and the states, along with other interested parties, to bring about the following outcomes: (a) ensure adequate Medicaid and Medicare funding for graduate medical education; (b) ensure adequate Disproportionate Share Hospital funding; (c) make the Medicare direct medical education per-resident cost figure more equitable across teaching hospitals while assuring adequate funding of all residency positions; (d) revise the Medicare and Medicaid funding formulas for graduate medical education to recognize the resources utilized for training in non-hospital settings; (e) stabilize funding for pediatric residency training in children’s hospitals; (f) explore the possibility of extending full direct medical education per-resident payment beyond the time of first board eligibility for specialties/subspecialties in shortage/defined need; (g) identify funding sources to increase the number of graduate medical education positions, especially in or adjacent to physician shortage/underserved areas and in undersupplied specialties; and (h) act on existing policy by seeking federal legislation requiring all health insurers to support graduate medical education through an all-payer trust fund created for this purpose; and (2) other interested parties to ensure adequate funding to support medical school educational programs, including creating mechanisms to fund additional medical school positions.

CME Rep. 7, A-05 Reaffirmation I-06 Reaffirmation I-07 Reaffirmed: Res. 921, I-12 Reaffirmation A-13 Reaffirmed: CME Rep. 5, A-13

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 health care 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. Sub. Res. 314, A-07 Reaffirmation I-07 Reaffirmed: CME Rep. 4, I-08 Reaffirmed: Sub. Res. 314, A-09 Reaffirmed: CME Rep. 3, I-09 Reaffirmation A-11 Appended: Res. 910, I-11 Reaffirmed in lieu of Res. 303, A-12 Reaffirmed in lieu of Res. 324, A-12 Reaffirmation: I-12 Reaffirmation A-13 Appended: Res. 320, A-13 Appended: CME Rep. 5, A-13 Appended: CME Rep. 7, A-14 Appended: Res. 304, A-14 Modified: CME Rep. 9, A-15 Appended: CME Rep. 1, I-15 Appended: Res. 902, I-15 Reaffirmed: CME Rep. 3, A-16 Appended: Res. 320, A-16 Appended: CME Rep. 04, A-16 Appended: CME Rep. 05, A-16 Reaffirmation A-16 Appended: Res. 323, A-17 Appended: CME Rep. 03, A-18 Appended: Res. 319, A-18 Reaffirmed in lieu of: Res. 960, I-18 Modified: Res. 233, A-19 Modified: BOT Res., A-19 Modified: BOT Rep. 25, A-19

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

1. Our AMA will ensure that actions to bolster the physician workforce must be part of any comprehensive federal health care reform. 2. Our AMA will work with the Centers for Medicare and Medicaid Services to explore ways to increase graduate medical education slots to accommodate the need for more physicians in the US. 3. Our AMA will work actively and in collaboration with the Association of American Medical Colleges and other interested stakeholders to rescind funding caps for GME imposed by the Balanced Budget Act of 1997. 4. Our AMA will actively advocate for expanded funding for entry and continued training positions in specialties and geographic regions with documented medical workforce shortages. 5. Our AMA will lobby Congress to find ways to increase graduate medical education funding to accommodate the projected need for more physicians. 6. Our AMA will work with key organizations, such as the US Health Resources and Services Administration, the Robert Graham Center, and the Cecil G. Sheps Center for Health Services Research, to: (A) support development of reports on the economic multiplier effect of each residency slot by geographic region and specialty; and (B) investigate the impact of GME funding on each state and its impact on that state's health care workforce and health outcomes.

Sub. Res. 314, A-09 Appended: Res. 316, A-12 Reaffirmed: Res. 921, I-12 Reaffirmation A-13 Reaffirmed: CME Rep. 5, A-13

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.

CME Rep. 3, I-09 Modified: CME Rep. 15, A-10 Reaffirmed in lieu of Res. 324, A-12 Reaffirmed: CME Rep. 5, A-13 Appended: CME Rep. 1, I-15

H-310.916, “Funding to Support Training of the Health Care Workforce”

1. Our American Medical Association will insist that any new GME funding to support graduate medical education positions be available only to Accreditation Council for Graduate Medical Education (ACGME) and/or American Osteopathic Association (AOA) accredited residency programs, and believes that funding made available to support the training of health care providers not be made at the expense of ACGME and/or AOA accredited residency programs.

2. Our AMA strongly advocates that: (A) there be no decreases in the current funding of MD and DO graduate medical education while there is a concurrent increase in funding of graduate medical education (GME) in other professions; and (B) there be at least proportional increases in the current funding of MD and DO graduate medical education similar to increases in funding of GME in other professions.

Sub. Res. 913, I-09 Appended: Res. 917, I-15

H-305.988, “Cost and Financing of Medical Education and Availability of First-Year Residency Positions”

1. believes that medical schools should further develop an information system based on common definitions to display the costs associated with undergraduate medical education; 2. in studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future; 3. believes that the primary goal of medical school is to educate students to become physicians and that despite the economies necessary to survive in an era of decreased funding, teaching functions must be maintained even if other commitments need to be reduced; 4. believes that a decrease in student enrollment in medical schools may not result in proportionate reduction of expenditures by the school if quality of education is to be maintained; 5. supports continued improvement of the AMA information system on expenditures of medical students to determine which items are included, and what the ranges of costs are; 6. supports continued study of the relationship between medical student indebtedness and career choice; 7. believes medical schools should avoid counterbalancing reductions in revenues from other sources through tuition and student fee increases that compromise their ability to attract students from diverse backgrounds; 8. supports expansion of the number of affiliations with

appropriate hospitals by institutions with accredited residency programs; 9. encourages for profit-hospitals to participate in medical education and training; 10. supports AMA monitoring of trends that may lead to a reduction in compensation and benefits provided to resident physicians; 11. encourages all sponsoring institutions to make financial information available to help residents manage their educational indebtedness; and 12. will advocate that resident and fellow trainees should not be financially responsible for their training. CME Rep. A, I-83 Reaffirmed: CLRPD Rep. 1, I-93 Res. 313, I-95 Reaffirmed by CME Rep. 13, A-97 Modified: CME Rep. 7, A-05 Modified: CME Rep. 13, A-06 Appended: Res. 321, A-15 Reaffirmed: CME Rep. 05, A-16 Modified: CME Rep. 04, A-16

H-465.988, “Educational Strategies for Meeting Rural Health Physician Shortage”

1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, the AMA recommends that: A. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents. B. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians. C. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians. D. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions. E. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas. F. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships. G. Our AMA support full funding of the new federal National Health Service Corps loan repayment program. H. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services. I. Our AMA continue its research investigation into the

impact of educational programs on the supply of rural physicians. J. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages. K. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible. L. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners. 2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency. 3. Our AMA will: (a) work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and (b) work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.

CME Rep. C, I-90 Reaffirmation A-00 Reaffirmation A-01 Reaffirmation I-01 Reaffirmed: CME Rep. 1, I-08 Reaffirmed: CEJA Rep. 06, A-18 Appended: Res. 956, I-18

H-200.954, “US Physician Shortage”

Our AMA: (1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US; (2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties; (3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US; (4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations; (5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates’ practice locations; (6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates’ eventual practice in underserved areas and with underserved populations; (7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas; (8) will continue to advocate for funding from all payers (public and private sector)

to increase the number of graduate medical education positions in specialties leading to first certification; (9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need; (10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and (11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.

Res. 807, I-03 Reaffirmation I-06 Reaffirmed: CME Rep. 7, A-08 Appended: CME Rep. 4, A-10 Appended: CME Rep. 16, A-10 Reaffirmation: I-12 Reaffirmation A-13 Appended: Res. 922, I-13 Modified: CME Rep. 7, A-14 Reaffirmed: CME Rep. 03, A-16

D-510.990, “Fixing the VA Physician Shortage with Physicians”

1. Our AMA will work with the VA to enhance its loan forgiveness efforts to further incentivize physician recruiting and retention and improve patient access in the Veterans Administration facilities. 2. Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate loan forgiveness when they practice in a Veterans Administration facility. 3. Our AMA will work with the Veterans Administration to minimize the administrative burdens that discourage or prevent non-VA physicians without compensation (WOCs) from volunteering their time to care for veterans. 4. Our AMA will: (a) continue to support the mission of the Department of Veterans Affairs Office of Academic Affiliations for expansion of graduate medical education (GME) residency positions; and (b) collaborate with appropriate stakeholder organizations to advocate for preservation of Veterans Health Administration funding for GME and support its efforts to expand GME residency positions in the federal budget and appropriations process.

Res. 1010, A-16 Appended: Res. 954, I-18

D-310.977, “National Resident Matching Program Reform”

Our AMA: (1) will work with the National Resident Matching Program to develop and distribute educational programs to better inform applicants about the NRMP matching process; (2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match; (3) will request that the NRMP explore the possibility of including the

Osteopathic Match in the NRMP Match; (4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises; (5) will work with the Accreditation Council for Graduate Medical Education and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians; (6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process; (7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements; (8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicant; (9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas; (10) will work with the National Resident Matching Program (NRMP) and Accreditation Council for Graduate Medical Education (ACGME) to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers; (11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs; (12) will

work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs; (13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program; (14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions; (15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match; (16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies; and (17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine.

CME Rep. 4, A-05 Appended: Res. 330, A-11 Appended: Res. 920, I-11 Appended: Res. 311, A-14 Appended: Res. 312, A-14 Appended: Res. 304, A-15 Appended: CME Rep. 03, A-16 Reaffirmation: A-16 Appended: CME Rep. 06, A-17 Appended: Res. 306, A-17 Modified: Speakers Rep. 01, A-17

H-310.912, "Residents and Fellows' Bill of Rights"

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines. 2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a

deeper understanding by resident physicians of the US health care system and to increase their communication skills. 3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights. 4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of \$200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.

5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.

6. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice. With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice. With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance. With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure

the submission of those documents to the requesting organization within thirty days of the request. D. A safe and supportive workplace with appropriate facilities. With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract. E. Adequate compensation and benefits that provide for resident well-being and health. (1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal. (2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages) and include appropriate adjustments for changes in the cost of living. (3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education. With regard to clinical and educational work hours, residents and fellows should experience: (1) A

reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information. G. Due process in cases of allegations of misconduct or poor performance. With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA. H. Access to and protection by institutional and accreditation authorities when reporting violations. With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey. CME Rep. 8, A-11 Appended: Res. 303, A-14 Reaffirmed: Res. 915, I-15 Appended: CME Rep. 04, A-16 Modified: CME Rep. 06, I-18

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- ii Elayne J. Heisler et. al., Cong. Research Serv., R44376, Federal Support for Graduate Medical Education: An Overview 1 (2018), <https://fas.org/sgp/crs/misc/R44376.pdf>.
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