

2023

Compendium of Graduate Medical Education Initiatives Report



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Introduction

The American Medical Association continues to focus on viable ways to improve graduate medical education (GME) to ensure medical students have the opportunity and support to fulfill training requirements and become practicing doctors.¹ In this vein, AMA's [FREIDA™](#) assists students in finding the right residency program for them by allowing students to search for a residency or fellowship from more than 12,000 programs — all accredited by the Accreditation Council for Graduate Medical Education (ACGME).

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. By 2034, the following is projected:

- A primary care physician shortage of **17,800** and **48,000** physicians.
- A shortfall across the non-primary care specialties of **21,000** and **77,100** physicians.
- A shortage of physicians in surgical specialties of **10,300** and **35,600**.

Major drivers of these projected trends continue to be an aging population requiring increasingly complex care concomitant with an aging physician workforce.ⁱ Exacerbating these projected trends is the COVID-19 pandemic, increasing burnout rates and accelerating retirement. According to a March 2021 survey conducted by Merritt Hawkins for the Physicians Foundation, 37 percent of physicians would like to retire in the next year.ⁱⁱ The full impact of the COVID-19 pandemic on the physician workforce is still being determined.

This issue of a shortage of residency slots is further exacerbated by the fact that according to data released by the Health Resources and Services Administration (HRSA) in December 2022, there were almost 99.6 million people living in primary medical health professional shortage areas (HPSAs). As a result, 17,065 practitioners are currently needed to remove the existing shortage designations.ⁱⁱⁱ 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 governments 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.^{iv}

¹ This Compendium was originally developed in 2015 through a joint effort by the AMA's Council on Legislation and Council on Medical Education.

Although the federal government is not the sole contributor to GME funding, it is by far the largest single source, primarily through Medicare funding, which paid an estimated \$16.2 billion in FY2020.^v 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. In FY2020, Medicare paid \$4.5 billion for DGME, supporting 98,542 full-time equivalent (FTE) resident physicians.^{vi} Indirect GME (IME) payments, which represents 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. In FY2020, Medicare paid an estimated \$11.68 billion for IME, supporting 98,542 FTEs.^{vii} Both IME and DGME payments are derived from complex formulas and are not designed to account for differences in costs resulting from training residents in different specialties. The Department of Veterans Affairs, the Health Resources and Services Administration, Medicaid, and the Children’s Health Insurance Program are other federal sources of GME funding.^{viii} 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 these services.

A brief summary of current GME funding^{ix}

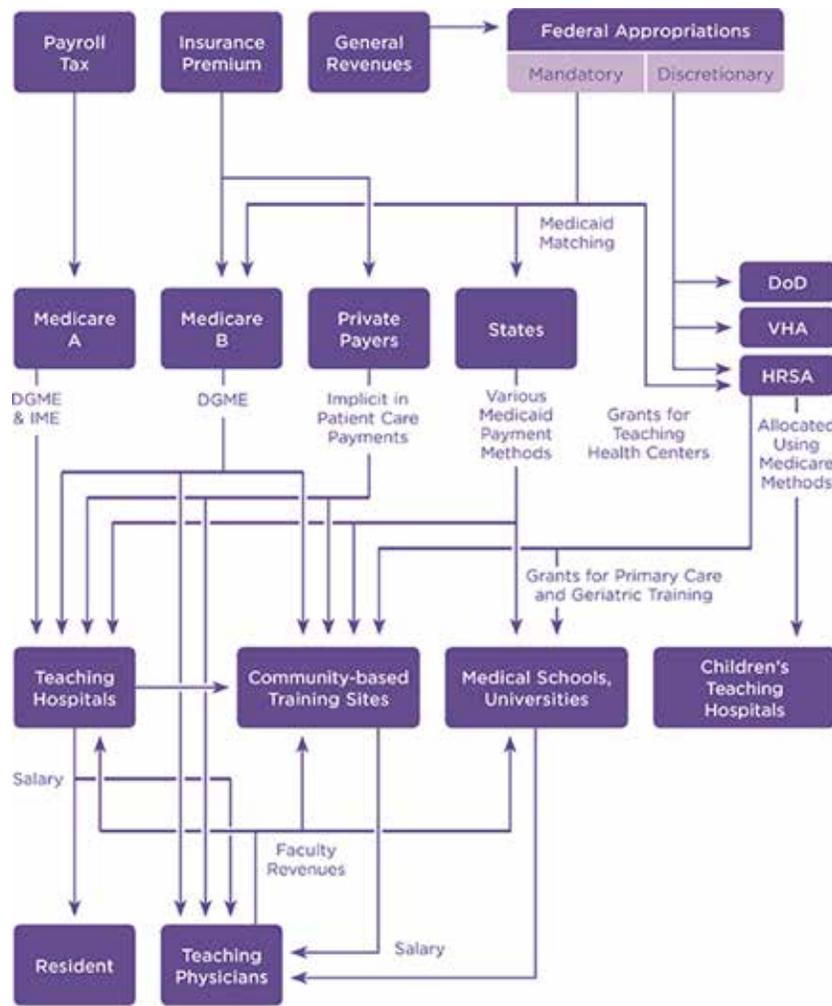


FIGURE 1: Current flow of GME funds

NOTE: DGME = direct graduate medical education; DoD = Department of Defense; HRSA = Health Resources and Services Administration; IME = indirect medical education.

SOURCE: Adapted from [Wynn, 2012](#) (Committee of Interns and Residents Policy and Education Initiative White Paper, “Implementing the 2009 Institute of Medicine recommendations on resident physician work hours, supervision, and safety”).

Medicare GME caps

Congress enacted the Balanced Budget Act of 1997 (P.L. 105-33), which limits Medicare's GME—most hospitals 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 the new teaching programs' fifth year; this is meant to offer institutions time to build and scale their programs to appropriate levels.

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. Cap-flexibility would not solve the issues created by the GME cap, but it is a positive step towards helping to address residency slot shortages.

As such, the AMA has policy in support of cap-flex, and continues to closely work with congressional staff, as appropriate, to further cap-flex policy.^x In addition, the AMA submitted letters in support of cap-flex to the administration in [2017](#)^{xi} and again in [2019](#)^{xii} and voiced support for H.R. 6090/S. 3390, "Physician Shortage GME Cap Flex Act of 2020."

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 percent. Medicare data show that in 2018, 70 percent of hospitals were over one or both of their IME or DGME caps on Medicare-funded residents, and 20 percent of hospitals were under one or both of their caps.^{xiii} Generally, these increases have been in subspecialties (i.e., for fellowship training) because subspecialty services tend to generate higher revenue or impose a lower cost burden on hospitals. In addition, some Medicare GME slots have been redistributed since the cap was enacted. For example, the Affordable Care Act included two redistribution programs—the first redistributes unused slots, and the second 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.

Furthermore, based on the projected physician shortfall that is expected by 2034, the cap established in 1997 is outdated and will continue to cause stress on a health care system that is already beginning to show signs of strain in rural and underserved communities.

Medicaid GME funding

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 most recent 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 percent or more compared to 2015 levels.^{xv}

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 percent 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.^{xvi} A few examples of AMA advocacy within VA GME programs include:

- The 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), which included a provision to establish a new pilot program for GME in underserved areas. The AMA offered [comments](#)^{xvii} on the proposed rule.
- The Department of Veterans Affairs (VA) Proposed Rule “RIN 2900- AR01—VA Pilot Program on Graduate Medical Education and Residency” creates a VA pilot program that would provide medical residency positions, enabling the VA to fund residents training in covered facilities, and pay for certain costs of new residency programs. The AMA offered its [comments](#)^{xviii} in support of the proposed rule and pilot program. This program, known as the VA Pilot Program on Graduate Medical Education and Residency (PPGMER), is separate from the VA’s general GME programming under 38 U.S.C. 7302(e) and is a time-limited pilot program that will sunset on August 7, 2031, unless statutorily reauthorized or made permanent.

Furthermore, the AMA also recently [voiced](#)^{xix} its 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](#)^{xx} with other health care organizations on this issue.

Private or alternative funding for GME

Kaiser Permanente, a large, integrated, population-based health care delivery system in the Western U.S., has been one of the largest private contributors to GME funding through its integrated residency programs, according to a 2013 report on GME initiatives.^{xxi} Kaiser hosts residency positions in five regions (Northern and Southern California, the Pacific Northwest, Colorado, and Hawaii). These collective programs support 900

full-time equivalent residents in over 30 specialties. Residents in the Kaiser Permanente system are hosted primarily through Kaiser itself (600 residents), but affiliate programs also send residents to train within the Kaiser system for some duration of time. In total, 3,000 individuals per year rotate through the Kaiser system for training. Kaiser has been very successful in retaining trainees following completion of residency training, with one-third to one-half of trainees staying and practicing in the Kaiser system. Savings on physician recruitment are then used to support Kaiser’s resident complement.^{xxii}

Additional private GME funding includes the Blue Cross Blue Shield of North Carolina Foundation which 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.

Furthermore, 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.^{xxiii} The Rheumatology Research Foundation additionally administers the Fellowship Training Award for Workforce Expansion to support the training of a rheumatology fellow at an institution that has previously been unable to fill all of their ACGME-approved slots due to funding constraints or creation of a new slot or 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 was supported by a pharmaceutical company 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.^{xxiv}

Private equity in GME

The most recent results of the National GME Census of active GME programs indicated that 7,695 programs' trainees are paid by a nonprofit entity; 1,620 programs' trainees are paid by a for-profit entity, while 3,550 programs did not answer.^{xxv} It is important to note that the salary-paying entity may not always be the same as the sponsoring institution or hospital. Currently, at least 14 emergency medicine residency programs are owned by lay entity corporations (i.e., no physician owner) in 10 different states.^{xxvi} The potential for medical education to be unduly influenced by the interests of a corporation, which is beholden to the concerns of shareholders, is disquieting.

The Resident and Student Association of the American Academy of Emergency Medicine has developed questions related to ownership/sponsorship of a program that students can ask of programs during the application or interview process. These include:^{xxvii}

- “Are the faculty employed by the hospital/medical school/a group?
- Which type of group? Do the faculty have incentives built around their teaching scores?
- Is there a particular type of post-residency practice you try and direct your graduates to?
- How do they get educated as to the various post-residency options?
- What type of position do most residents go to after they complete training?
- If mostly academic, do they go to work for physician-owned groups or large companies?
- Is the residency sponsored by any entity other than Medicare?
- If so, by whom? If a large amount is sponsored by an entity other than Medicare, does this sponsor affect my education in any way? Have there been issues with this sponsor in relation to this residency program in the past? Would this entity sponsoring my training bias me in any way?”

One of the largest for-profit hospital companies in the U.S., HCA Healthcare, currently has 33 hospitals sponsoring 162 ACGME-accredited programs in 12 states.^{xxviii} HCA Healthcare also operates hospitals that are affiliated with training programs (but are not sponsors). One positive outcome of increased involvement in GME by this and other for-profit entities has been the growth of GME in areas with high-population growth, such as Florida, Georgia, Texas, and Nevada, that have long been stymied in their ability to increase GME positions. As with non-profit training institutions, for-profit sponsors likely benefit from the work that residents provide, as well as the built-in pool of physician candidates for employment.^{xxix}

At the same time, concerns of physician professional autonomy, due process, and conflict of interest may be more common when there is a fiduciary responsibility to shareholders by the sponsors or affiliates of training programs. Recent incidents in which for-profit corporations have purchased and then unexpectedly closed training hospitals have raised apprehensions regarding the long-term interests of corporations and their connection to GME. In 2019, for example, Ohio Valley Medical Center was closed after being purchased by Alecto Healthcare Services, LLC in 2017.^{xxx}

Also in 2019, Hahnemann University Hospital (HUH) was abruptly closed shortly after being purchased in 2018 by American Academic Health System, LLC (AAHS) (an affiliate of the private equity firm Paladin Healthcare Capital, LLC).

The closure of HUH resulted in the displacement of 570 residents from over 30 residency and fellowship programs; the closure of Ohio Valley displaced 32 residents from two programs.

To improve their financial gain, AAHS attempted to sell its government-funded residency slots as “assets” during bankruptcy proceedings, which was allowed by the presiding judge at the time. Bids included a coalition of local hospitals (\$55 million) intending to keep the residency positions in the Philadelphia region, as well as a health care firm in California (\$60 million) that wanted to increase the number of funded physicians in its hospitals.^{xxxix} However, the Centers for Medicare & Medicaid Services (CMS) objected to the judge’s ruling, arguing that the allocation of Medicare-funded slots is CMS’ sole purview and that the auction would set a dangerous precedent. A judge paused the sale, and the auction did not go forward.^{xxxix,xxxiii} Subsequently, the slots that were previously held by HUH were redistributed by CMS in accordance with Section 1556 regulations, however, the legal challenge regarding whether or not residency slots can be sold is still pending.^{xxxiv}

As such, attention has been increasing regarding the future of health care delivery, as well as GME, in light of financial pressures on training institutions and affiliated practice sites. AMA Policy H-310.943 “Closing of Residency Programs” includes many recommendations resulting from the sudden closure of the HUH residency programs. More information on what to do following closure of a residency program can be found [here](#).^{xxxv}

More information about the impact of private equity on medical training can be found in a [2022 Report](#) from the AMA Council on Medical Education.

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.”^{xxxvi} 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 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 35 percent since 2002, according to “Results of the 2020 Medical School Enrollment Survey.” Combined with first-year matriculation at osteopathic schools, medical student enrollment is now 59 percent higher than in 2002–03.^{xxxvii}

Though the number of medical students continues to grow, residency training has not kept pace with the expanding, aging population and their complex health needs. Residency training positions have expanded at a rate of just 1 percent a year, primarily due to the congressional cap on federal funding in the Balanced Budget Act of 1997.^{xxxviii} This 1 percent growth has been offset by recent Congressional action to increase the total number of residency slots by 1,000 slots in the Consolidated Appropriations Act, 2021, and 200 slots in the Consolidated Appropriations Act, 2023, however, these one times expansions are not enough.

Applicants Versus First Year Slots Available

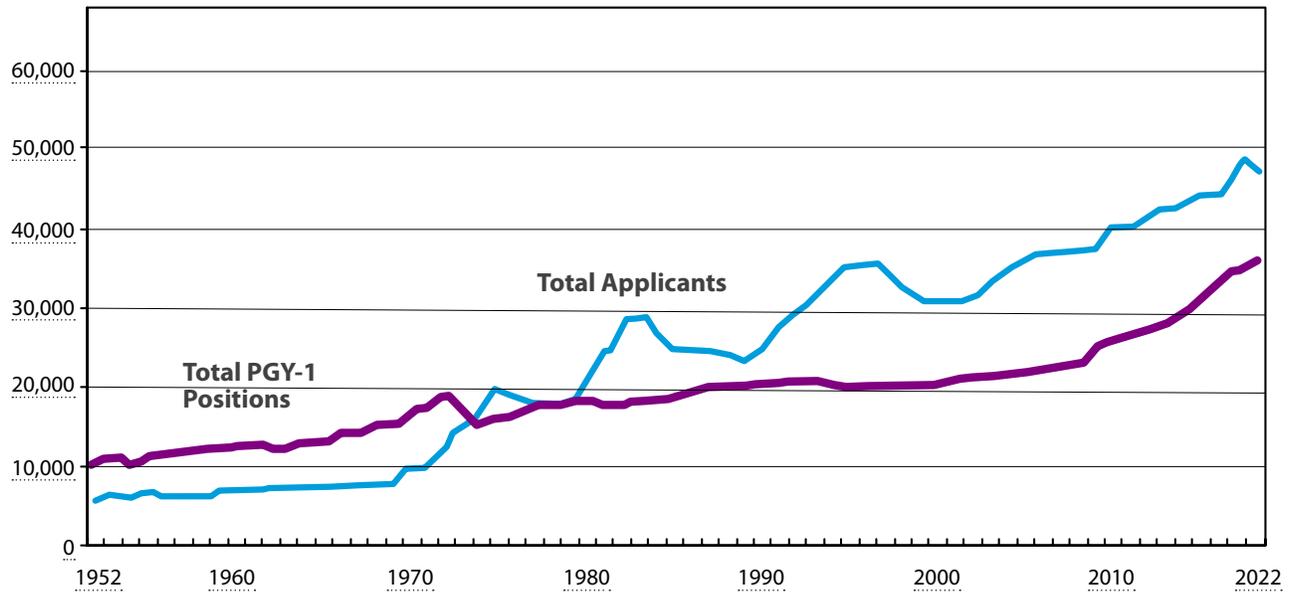


Figure 2: Applicants and 1st year positions in the match, 1952–2022^{xiv}

Current GME initiatives

Several stakeholders have offered potential GME reforms. While these proposals differ, the following information outlines key aspects from some of the most recent proposals 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),^{xxxix} the only federal advisory panel charged with overseeing GME and supporting the existing physician workforce (including rural health, rural residencies and payment models), drafted a [Report to Congress](#)^{xi} and the secretary of the HHS documenting the need for GME reform and recommending the development of a national strategic plan for GME.^{xii} 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.”^{xliii}

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

- 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

In 2022, COGME completed another [report](#) to Congress on “Strengthening the Rural Health Workforce to Improve Health Outcomes in Rural Communities”, its first since the above-mentioned 2017 report. This report recognized that health disparities between rural and urban areas tripled between 1999 and 2019.^{xliv}

As such, COGME recommended that, in order to improve access to care for rural communities, the U.S. health care system should be restructured according to five basic principles:^{xlv}

- Assessing and Planning for the Specific Needs of Rural Communities
- Focusing on Generalism and Team-Based Care
- Integrating the Community into the Workforce
- Developing Outcome Measures that Align Workforce Investments with Population Health Needs in Rural Communities
- Creating Financing Mechanisms that Sustain Rural Training and Practice

As a result, COGME called on Congress and the Department of Health & Human Services to prioritize the following six (6) recommendations:^{xlvi}

- Federal funding for a comprehensive assessment of rural health needs to identify gaps in essential care
- Federal training investments that follow the National Academy of Medicine recommendation to link GME funding to population health needs
- Directing the HHS Secretary to develop a set of measures that ensure value and return on public investment in GME financing with a focus on rural areas including:
 - Developing measures concerning the diversity and cultural competence of the workforce, to ensure that the workforce is concordant with the communities being served
 - Requiring CMS to create mechanisms of financial accountability for GME payments, for all GME programs, and link financial accountability to downstream training outcomes including patient outcomes, population health, and health professional wellbeing and resilience
- HHS invest in sustainable solutions that focus on building a stable health care workforce in rural communities, including:
 - Additional funds for pipeline programs through scholarships for individuals from rural communities to pursue professional qualifications
 - A program to support the relocation, resettlement, and retention of practitioners and their families to rural locations
- CMS work with HRSA and other agencies within HHS to identify and eliminate regulatory and financial barriers and create incentives to health professional education, training expansion, and innovation that promote rural population health, including the following steps:
 - Enable rural-specific training expansion for disciplines with shortages and offer regulatory flexibility in rural training programs that promote rural health access
 - Offer Medicare GME cap flexibility or exceptions for sponsoring institutions starting new rural-based training programs, such as Rural Training Tracks, in needed specialty and geographic areas

- Craft regulations that permit rural hospitals to establish fair ‘total resident amounts’ consistent with their higher costs of training
- CMS support and test sustainable alternative payment models (APMs) that enhance the delivery of team-based interprofessional education and practice

COGME has held and continues to hold [public meetings](#) to further discuss these important issues.^{xlvii}

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.^{xlviii}

AMA’s “Reimagining Residency” initiative

In 2013, the AMA instituted the “Accelerating Change in Medical Education” initiative which provides grants to medical schools to support undergraduate medical education innovation. The [“Reimagining Residency”](#) initiative, launched in 2019, is the next phase in this effort.^{xlix} 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](#) 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 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 to urge their members of Congress not to make cuts to GME.

Medical Student Advocacy Conference (MAC) and Medical Student National Advocacy Week (NAW)

Each year, over 400 medical students participate in the [MAC](#)ⁱ and NAW advocating on topics that medical students care about including increased GME funding and reform around student loans and retirement. Through these programs medical students learn about relevant legislation and lobby their members of Congress on Capitol Hill in Washington, D.C. for MAC or in their districts for NAW.^{li, lii}

Federal regulatory changes related to GME and loan forgiveness and repayment

The AMA has consistently advocated for positive changes in graduate medical education and student loan forgiveness and repayment. Examples of some of this work is provided below:

- On August 16, 2019, CMS released the fiscal year 2020 hospital inpatient prospective payment system (IPPS) [final rule](#).^{liii} The rule finalizes several proposals relating to hospital payment policy, including one that changes how 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 October 1, 2019. (See the [AMA’s comment letter](#)).^{liv}
- On August 17, 2018, CMS released the agency’s fiscal year 2019 IPPS [final rule](#).^{lv} 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](#)).^{lvi}

- On October 1, 2020, CMS, via the FY 2021 Inpatient Prospective Payment Services (IPPS) Proposed Rule,^{lvii} made changes related to closing hospitals and closing residency programs. CMS focused 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. Previously, residents who left a closed residency program with a federally funded GME slot had to be physically present at the closing of the “home” hospital on the day the home hospital closed in order for funds to be transferable to the “receiving” hospital. However, now residents no longer have to be physically present at the hospital on the day prior to the closure of the hospital to be eligible for a funding transfer and instead can transfer during the winding down phases of their current placements. The [AMA commented](#)^{lviii} on the IPPS Proposed Rule (CMS-1735-P).
- On June 1, 2020, the [AMA commented](#)^{lix} on CMS-1744-IFC; Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency rule. In this letter, the 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. Following the end of the Public Health Emergency, these regulations will revert back to pre-COVID-19 rules.
- On October 5, 2020, the AMA commented on a CMS proposed rule. In this letter, our [AMA supported](#)^{lx} permanently allowing the supervision of residents in teaching settings through audio/video real-

time communications technology and allowing the virtual presence of teaching physicians during Medicare telehealth services, advocating that this change should be made permanent. Additionally, the AMA supported permanently allowing residents to moonlight in the inpatient setting and permanently expanding the services that may be offered under the primary care exception. Following the end of the Public Health Emergency, these regulations will revert back to pre-COVID-19 rules with exemptions for virtual supervision made for rural facilities.

- On June 28, 2021, the [AMA signed-on to a letter](#)^{lxi} urging CMS to create rules to beneficially distribute the 1,000 new GME slots in the Consolidated Appropriations Act, 2021.
- On February 25, 2022 the [AMA sent a letter](#)^{lxii} offering our comments to the CMS on the 2022 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS). Specifically, our comments focused on Graduate Medical Education (GME) and other related provisions contained in the final rule.
- On August 12, 2022, the [AMA sent a letter](#)^{lxiii} commenting on the Student Assistance General Provisions, Federal Perkins Loan Program, Federal Family Education Loan Program, and William D. Ford Federal Direct Loan Program proposed rule. The AMA commented on the definition of employee or employed and the need to change this definition so that physicians that are impacted by the corporate practice of medicine can access the PSLF program. Through this rule, the Department of Education created a new income-driven repayment plan that will reduce monthly payments by lowering the amount of income that can be considered discretionary -- from 10 percent to 5 percent. Borrowers with both undergraduate and graduate loans will pay a weighted average rate. The new rule will also eliminate all interest capitalization that is not required by statute. (Interest capitalization occurs when unpaid interest is added to a borrower's principal balance, increasing the total amount that borrowers have to pay.) The new rule encourages automatic discharges for borrowers who are eligible for loan relief because their school closed, they have a total and permanent disability, or their loan was falsely certified. The new rule also prevents institutions of higher education from forcing students to sign mandatory arbitration agreements and class action waivers.

Federal legislation for GME expansion and student loans

The AMA successfully advocated for passage of the following legislation during the 117th Congress:

- The Consolidated Appropriations Act, 2021 included the creation of 200 new Medicare-funded GME positions per year over five years at both rural and urban teaching hospitals. At least 10 percent of such positions must be assigned to rural hospitals, teaching hospitals, hospitals that serve areas designated as health professional shortage areas (HPSAs), and hospitals in states with new medical schools.^{lxiv}
- The Consolidated Appropriations Act, 2023 included the creation of 200 new AMA-endorsed Medicare-supported graduate medical education (GME) slots in FY 2026, with 100 of these slots specifically allocated to psychiatry and psychiatry subspecialties, and no restrictions on the remaining positions. Under the proposed distribution framework, the following categories of teaching hospitals will each receive 10 percent of the slots: rural hospitals, hospitals over their cap, hospitals in states with new medical schools or branch campuses, and hospitals serving Health Professional Shortage Areas.^{lxv}
- As part of the Consolidated Appropriations Act, 2023, The Retirement Parity for Student Loans Act ([H.R. 2917/S. 1443](#)) was passed. This legislation permits 401(k), 403(b), SIMPLE IRA and governmental 457(b) retirement plans to make matching contributions to workers as if their student loan payments were salary reduction contributions. Under this voluntary proposal for employers, graduates who cannot afford to save money above their student loan repayments would no longer be forced to forego the important employer match for retirement contributions. AMA strongly advocated for these provisions and wrote letters,^{lxvi, lxvii} of support as well as convened medical student advocacy around this issue during the 2022 Medical Student National Advocacy Week.

The AMA advocated for the following federal bills that were 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 submitted a [support letter](#).^{lxviii}
- 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 submitted [support letters](#).^{lxix}
- 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 submitted a [support letter](#).^{lxx}
- 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 expansion of the Conrad 30 program.
- 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 submitted a [support letter](#).^{lxxi}
- [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 who aid in

responding to the COVID-19 crisis. The AMA submitted a [support letter](#).^{lxxii}

- 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](#).^{lxxiii}
- Health and Economic Recovery Omnibus Emergency Solutions Act (HEROES Act) (H.R. 6800) – The bill is a 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 contained 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](#).^{lxxiv}
- 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](#).^{lxxv} and the [Senate](#).^{lxxvi}

The AMA advocated for the following federal bills that were introduced during the 117th Congress (2021–2022):

- Strengthening America’s Health Care Readiness Act (S. 54) - This bill would provide additional funding for the National Health Service Corps (NHSC), the Nurse Corps, and establish a National Health Service Corps Emergency Service demonstration project. The COVID-19 pandemic highlighted the need for additional emergency capacities and underscored the health workforce shortages and disparities that exist throughout the nation. This bill would bring access to care for patients and welcome relief to the physicians, residents, and nurses who have been on the front lines throughout the pandemic caring for our sickest patients. The AMA [sent a letter of support](#) and also [signed-on to an additional letter of support](#).^{lxxvii, lxxviii}
- Resident Physician Shortage Reduction Act (H.R. 2256 and S. 834) - This bill would gradually raise the number of Medicare-supported GME positions by 2,000 per year for seven years, for a total of 14,000 new slots. A share of these positions would be targeted to hospitals with diverse needs including hospitals in rural areas, hospitals serving patients from health professional shortage areas (HPSAs), hospitals in states with new medical schools or branch campuses, and hospitals already training over their caps.^{lxxix}
- Student Loan Forgiveness for Frontline Health Workers Act (H.R. 2418 and S. 3828) – This bill would provide student loan relief to physicians, residents, medical students, and other health care professions who perform work to combat, control, and recover from COVID-19.^{lxxx}
- Rural America Health Corps Act (S. 924) - This bill would establish a demonstration program to provide payments on qualified loans for individuals eligible for, but not currently participating in, the National Health Service Corps (NHSC) Loan Repayment Program who agree to a five-year period of obligated full-time service in a rural health professional shortage area.^{lxxxi}
- Substance Use Disorder Workforce Act or the Opioid Workforce Act of 2021 (H.R. 3441 and S. 1438) – This bill would provide 1,000 additional Medicare-supported GME positions in hospitals that have, or are in the process of establishing, accredited residency programs in addiction medicine, addiction psychiatry, or pain medicine.^{lxxxii, lxxxiii}
- Doctors of Community Act or the “DOC Act” (H.R. 3671) - This legislation would permanently authorize the Teaching Health Center Graduate Medical Education (THCGME) program.^{lxxxiv}
- Physician Shortage GME Cap Flex Act of 2021 (H.R. 4014 and S. 2094) - This legislation would help to address our national physician workforce shortage by providing teaching hospitals an additional five years to set their Medicare Graduate Medical Education (GME) cap if they establish residency training programs in primary care or specialties that are facing shortages.^{lxxxv, lxxxvi}

- Resident Education Deferred Interest (REDI) Act ([H.R. 4122](#) and [S. 3658](#)) – This bill would allow borrowers to qualify for interest-free deferment on their student loans while serving in a medical internship or residency program.^{lxxxvii, lxxxviii}
- Bolstering Infectious Outbreaks (BIO) Preparedness Workforce Act of 2021 ([H.R. 5602](#) and [S. 3422](#)) - This bill would help alleviate workforce shortages to strengthen our preparedness for future public health emergencies and build the next generation of infectious diseases (ID) experts and laboratory professionals who will respond to emerging and ongoing health threats.^{lxxxix, xc}
- Indian Health Service Health Professions Tax Fairness Act of 2022 ([H.R. 7539](#)) - This bill would amend the Internal Revenue Code to exclude payments made under the Indian Health Service Loan Repayment Program (IHS LRP) and certain amounts received under the Indian Health Professions Scholarships Program (IHPSP) from gross income payments.^{xc}
- Specialty Physicians Advancing Rural Care Act or the “SPARC Act” ([S. 4330](#)) – This bill would amend the Public Health Service Act to authorize a loan repayment program to encourage specialty medicine physicians to serve in rural communities experiencing a shortage of specialty medicine physicians.^{xcii}

The 118th Congress (2023-2024) has just begun and the AMA will continue to voice strong support for Graduate Medical Education.

Legal update

There are several court cases that have impacted medical education in recent years:

- 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](#),^{xciii} 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’ 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).

- In late 2022, the Biden Administration proposed a one-time student loan cancellation program that would allow millions of borrowers to receive \$10,000 of debt cancellation if the borrowers’ annual incomes were less than \$125,000 or, for married couples, were less than \$250,000. If the borrower received Pell Grants in college and they meet the income requirements, then they could receive \$20,000 of loan forgiveness. This program faced immediate legal challenges culminating in a Supreme Court case. An initial challenge in *Biden v. Nebraska* was brought forward by Republican-led states who argued that Biden’s initiative deprived state treasuries of revenue because state-affiliated programs administer the Family Federal Education Loan Program (FFELP).^{xciv} This program has some financial ties to the states and forgiveness would decrease the revenue states could receive via this program if borrowers consolidate their student loans and obtain loan forgiveness. The Eighth Circuit Court of Appeals allowed a nationwide injunction to go into effect, temporarily prohibiting the Administration from discharging any debt. A second case out of the Fifth Circuit Court of Appeals, *Department of Education v. Brown*, consisted of conservative-leaning groups representing individual borrowers arguing that the Biden Administration improperly relied on emergency regulatory authority to enact the program, which unlawfully bypassed normal federal regulatory procedures and

deprived borrowers of the opportunity to engage in public input. These two cases were considered by the Supreme Court on February 28, 2022. As of publication, the outcome of this Supreme Court case is pending.^{xcv}

- In early 2023, an affirmative action case concerning medical school admissions was brought in Texas. In *Stewart v. Texas Tech University Health Sciences Center et al.*, the plaintiff, a white male Texan who was rejected by six Texas medical schools, alleged that, “[e]ach of the defendant medical schools and universities, along with nearly every medical school and university in the United States, discriminates on account of race and sex when admitting students by giving discriminatory preferences to females and non-Asian minorities, and by discriminating against whites, Asians, and men.”^{xcvi} The outcome of this case is pending but the decision will likely be impacted by the outcome of two cases regarding affirmative action and race conscious admissions that are currently being jointly considered by the Supreme Court - *Students for Fair Admissions Inc. v. President & Fellows of Harvard College* and *Students for Fair Admissions, Inc. v. University of North Carolina*.

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.

According to the U.S. Department of State, for calendar year (CY) 2022, there were 3,302 J-1 physicians participating in the exchange program. For CY 2022 the top three “sending countries” for J-1 physicians were: Canada 736; India 577; and Pakistan 314. The top three “receiving U.S. states” for J-1 physicians in CY 2021 were: New York 653; Michigan 249; and Pennsylvania 235.^{xcvii}

The graphics below, developed by ECFMG, highlights the IMGs working with ECFMG each year to obtain clinical training in the U.S.^{cv}

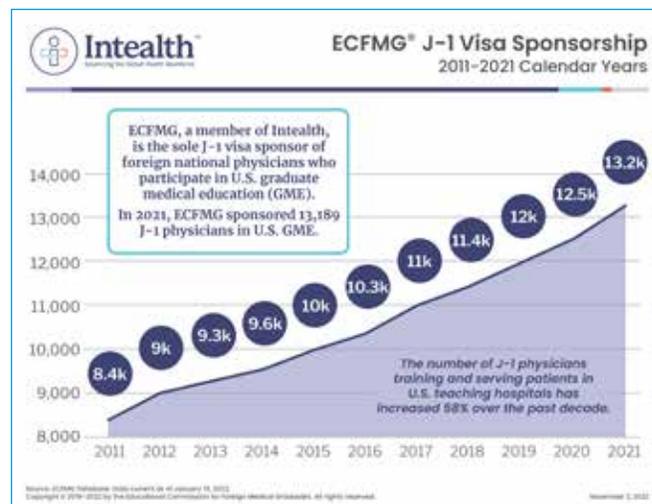


FIGURE 3: J-1 Visa sponsorship

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 117th Congress, the AMA [supported](#) and helped draft the bipartisan ([H.R.3541/S.1810](#)) Conrad State 30 and Physician Access Reauthorization Act.^{xcviii, xcix} 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 ([2019](#),^c [2017](#),^{ci} [2015](#),^{cii} [2013](#),^{ciii} [2012](#),^{civ}) and will continue to support the bill until passage.

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.^{cvi} In 2019, of the 938,966 practicing physicians in the United States, 232,190 (24.7 percent) did not graduate from a U.S. or Canadian medical school.^{cvii}

GME unionization

The first resident union was established in 1934 at the Intern Council of Greater New York.^{cix} The union was organized to address the issues of compensation, limited learning opportunities, and concerns about work conditions. In 1999, the National Labor Relations Board (NLRB) ruled that medical residents should be deemed employees when it comes to federal labor rules and thus are legally able to unionize. In response to the COVID-19 pandemic and the associated strained health care workforce, a growing number of residency programs are unionizing. The Committee of Interns and Residents (CIR) is the biggest house staff union in the United States. In late 2019, it had 16,000 members and at the end of 2022 membership had increased to over 24,500.^{cx} Additionally, there were at least 69 GME-unionized programs at the end of 2022.^{cxii}

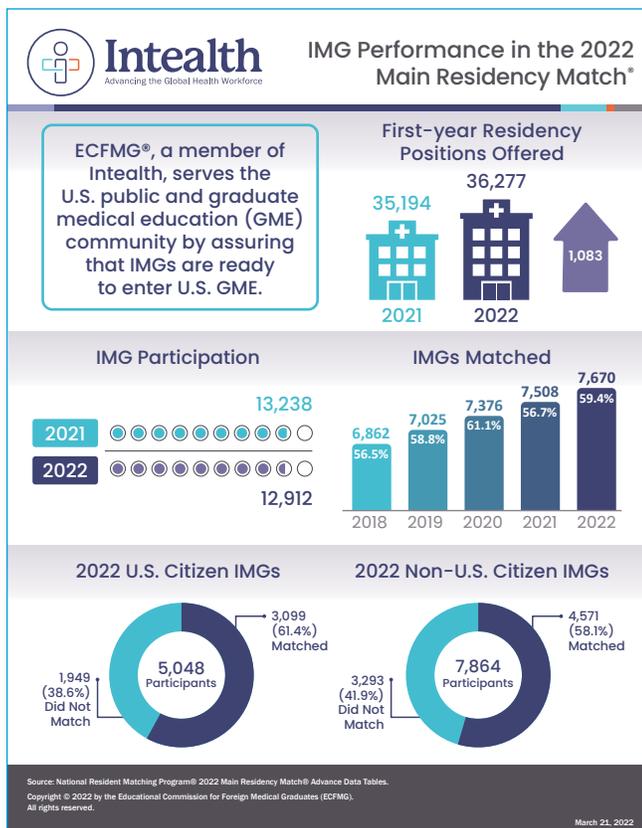


FIGURE 4: IMG performance in the 2022 Main Residency Match^{cvi}

State and regional 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 collection of some of these 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.

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. In the class of 2026, there are 253 WWAMI students.^{cxii}

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 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 support 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
- Olympia Longitudinal Integrated Clerkship (Olympia LIC): An 11-month longitudinal clerkship with an emphasis on community care based in the small urban community of Olympia, Washington allowing students over time to experience multiple medical disciplines.

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 (more information below).
- 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 percent of the population in the five Pacific Northwest states lives in rural and largely underserved communities.

National Area Health Education Center Network

The National Area Health Education Center Network (AHEC) is a national program that works to improve the diversity, distribution and quality of the health workforce throughout the country, 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.

Beyond WWAMI, new medical schools have been opening in health professional shortage areas to encourage physician-retention following residency. Many of these schools also have longitudinal programs, like WWAMI's TRUST program.

To determine if a specific medical school has a similar program, check their website or contact the school directly.

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 2022, California committed \$20.75 million through the Song-Brown Healthcare Workforce Training Programs for 166 primary care residency positions.^{cxiii, cxiv}

In 2017, The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) went into effect, increasing the excise tax rate on cigarettes and electronic cigarettes.^{cxv} Funds obtained through this proposition are used to support access to health care for low-income Californians covered by the Medi-Cal program, including through supporting residency positions. CalMedForce is funded by Proposition 56 and has provided 5 cohorts of awardees, as of 2022, funding for residency programs that support and expand the physician workforce to meet the demands of California's diverse and growing patient population, with a focus on medically underserved populations.^{cxvi} In 2022, \$37.9

million was awarded to 129 residency programs across 27 counties to support 210 resident positions in primary care and emergency medicine.^{cxvii}

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, such as 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. 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 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 to provide uncompensated preceptorship training to medical students. Physicians can receive up to \$8,500 in tax credits for 10 rotations per calendar year.

The Georgia State Fiscal Year 2022 Appropriations Act allocated funds for 188 new residency slots in primary care medicine.^{cxviii}

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.

In 2022, Senate Bill 2657 was signed into law which increased funds for the University of Hawaii, John A. Burns School of Medicine's expansion of medical residency and medical student training opportunities on neighboring islands and with the U.S. Veterans Affairs Pacific Islands Healthcare System at sites across the state.^{cxix}

Idaho

In 2021, the Legislature allocated \$900K to build out 15 new Graduate Medical Education (GME) positions throughout the state and maintain current funding levels for existing residency training programs.^{cxix, cxxi}

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 residency grant or money from the graduate medical education fund must agree to provide matching funds equal to at least 25 percent 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 and as of 2022, the GME Board has awarded over \$20 million through the state's GME Expansion Plan, increasing Indiana's number of residency slots by more than 330.^{cxvii}

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). The TidalHealth Peninsula Regional Medical Center requested funding via the HSCRC to establish a GME program of 53 slots over a five-year period beginning with 10 residents in year 1. Staff at the HSCRC recommended that the Commissioners consider a standard whereby there will be no additional funding for GME slots, including PRMC, in the State until national funding of GME, per Medicare and Medicare Advantage beneficiaries, reaches levels equivalent to Maryland.^{cxviii} It is unclear what determination the Commissioners made based on the recommendations of staff at HSCRC.

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.

In 2015, the Minnesota Legislature enacted Minnesota Statute Section 144.1506 authorizing the Commissioner of Health to award grants to support new Primary Care Residency positions. The Minnesota Legislature has appropriated \$1,500,000 in grant funds for fiscal year 2023. Eligible primary care residency programs may receive up to \$75,000 for planning projects, and up to \$300,000 per new primary care residency slot, over three years.^{cxvix}

North Dakota

The Health Care Workforce Initiative, funded by the state government, will allow the University of North Dakota School of Medicine and Health Sciences to expand to have 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

Wisconsin's Graduate Medical Education Initiative was launched in 2013 by the Department of Health Services (DHS) to increase the number of physicians practicing in rural areas of the state.^{cxv} DHS has awarded 85 Grow Our Own grants to date, spurring \$53 million in public/private funds to be invested in growing the Wisconsin health care workforce. As a result of GME grants Wisconsin has an additional 145 residency slots.^{cxvi} The state provides funding for the Medical College of Wisconsin's (MCW) residency programs, primarily in underserved areas of Milwaukee.^{cxvii} The state also made a start-up investment for MCW's new programs in northeastern and central Wisconsin. In addition, the Wisconsin Department of Health Services continues to support 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.

Loan forgiveness and repayment programs

In 2022, 71 percent of medical students graduated with a median debt of \$200,000.^{cxviii} Moreover, the rising cost of medical school is showing no signs of abating. In fact, the average cost of attending public medical schools for first-year students in 2022-2023 increased by 4 percent from the prior year. As such, it is likely that medical students will have to carry even larger student loans in the future upon graduation. The enormous debt load medical students face is further compounded during their low-paying residency and fellowship training (which can last up to eight years post-graduation), especially for residents who are unable to begin repaying student debt immediately. In addition, even if they qualify to have their payments suspended during residency through deferment or forbearance processes,

their loans continue to accrue interest that is added to their already staggeringly high student loan balance. This cycle can lead to tens of thousands of dollars of additional debt due to interest accrual. When faced with the financial realities of managing significant medical school debt, students often pursue higher paying specialties leaving a significant shortage of primary care and family practice physicians. For example, one study indicated that 31 percent of medical students intended to pursue primary care in their first year of medical school, but due to debt and expected income, decided to switch to a higher paying specialty by the end of their fourth year.^{cxix}

To address this high student loan burden and the lack of physicians in underserved communities, there are several federal loan forgiveness programs. Additionally, 35 states and the District of Columbia have at least one 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 award dollar amounts allowed. Following is a sample of some of these programs.

Federal loan forgiveness and repayment programs

Public Service Loan Forgiveness (PSLF) Program

The PSLF Program forgives the remaining balance on your Direct Loans after you have made 120 qualifying monthly payments under a qualifying repayment plan while working full-time for a qualifying employer. To qualify for PSLF, physicians must be employed by a U.S. federal, state, local, or tribal government or not-for-profit organization, work full-time for that agency or organization, have a loan received under the William D. Ford Federal Direct Loans (or consolidate other federal student loans into a Direct Loan – only payments made on the new Direct Consolidation Loan can be counted towards the 120 payments), repay their loans under an income-driven repayment plan, and make 120 qualifying payments.

Amounts forgiven under the PSLF Program are not considered income by the Internal Revenue Service. Therefore, individuals will not have to pay federal income tax on the amount of Direct Loans that are forgiven.

Recent changes to the PSLF program that go into effect starting July 1, 2023, are aimed to help borrowers earn progress toward PSLF, simplify criteria to help borrowers certify employment, and provide opportunities to correct problems.^{cxx}

National Health Service Corps (NHSC) Loan Repayment

The National Health Service Corps has three loan repayment programs: the NHSC Loan Repayment Program, the NHSC Substance Use Disorder (SUD) Workforce Loan Repayment Program, and the NHSC Rural Community Loan Repayment Program. Physicians are eligible for all three programs, though each program has a different service commitment and amount that can be forgiven.

The NHSC Loan Repayment Program requires a 2-year service commitment at any NHSC-approved health care site and will repay up to \$50k for full-time employment, or \$25k for part-time. The NHSC SUD Workforce Loan Repayment Program and the NHSC Rural Community Loan Repayment Program both require a 3-year commitment. The NHSC SUD Workforce Loan Repayment Program will repay up to \$75k for full-time employment at any NHSC-approved SUD site and \$37.5k for part-time employment. The NHSC Rural Community Loan Repayment program will repay up to \$100k for full-time employment at any rural, NHSC-approved, SUD site and up to \$50k for part-time employment at those sites.

Physicians seeking repayment through these programs must be a provider (or be eligible to participate as a provider) in the Medicare, Medicaid, and the State Children’s Health Insurance Program, as appropriate.

Health Professionals Loan Repayment Program (HPLRP)

The Health Professionals Loan Repayment Program is administered by the Air Force, the Navy, the Army National Guard, the Air Force Reserve and will repay loans secured to finance health professional education approved by the Secretary of Defense as a critical specialty needed to meet wartime, combat medical skill shortages.

The HLRP allows for a maximum loan repayment of \$40k per year, minus about 25 percent in federal income taxes, which are taken out prior to disbursement. The maximum annual rate may be updated periodically by the Secretary of Defense. The service commitment to be eligible for HPLRP is a two-year active-duty obligation or one year of Reserve service for each year of benefits received. Maximum lifetime cap on repayment is dependent upon the service and reserve versus active-duty status.



FIGURE 5: Comparing NHSC loan repayment programs^{xxxi}

To be eligible for the HPLRP program, a physician must be enrolled in the final year of an approved residency program, must not be a current HPSP or FAP participant, be fully qualified in a health profession that has been determined to be necessary to meet identified skill shortages and must be qualified for, or hold an appointment as a commissioned officer in, one of the health professions.

Indian Health Service (IHS) Loan Repayment Program (LRP)

The LRP funds IHS clinicians to repay their eligible health profession education loans — up to \$40,000 — in exchange for an initial two-year service commitment to practice in health facilities serving American Indian and Alaska Native communities. Opportunities are based on Indian health program facilities with the greatest staffing needs in specific health profession disciplines. LRP participants, can extend their contract annually until their qualified student debt is paid off.

Title VII - Primary Care Loans Program

Title VII has several programs that support the development of a diverse physician workforce, including the Primary Care Loans (PCL) Program. The PCL program is funded by the Health Resources & Services Administration's (HRSA) Bureau of Health Workforce (BHW) to provide funds to participating medical schools through BHW's school-based scholarship and loan program. Long-term, low-interest rate loans are made available to full-time, economically disadvantaged students at participating medical schools to obtain a degree in allopathic or osteopathic medicine.

Students who receive loans under the PCL program agree to enter and complete residency training in primary care within four years after graduation and practice primary care for 10 years or until the loan is paid in full.

National Institutes of Health (NIH) Loan Repayment Programs

The NIH has two loan repayment programs for researchers both employed by NIH (Intramural) and not employed by NIH (Extramural). Awardees for either program may apply for subsequent, competitive renewal awards as long as they meet program eligibility. Eligible physicians must have qualifying educational debt equal to at least 20 percent of their base salary from the institution supporting their research and be conducting qualifying research.

Payment projections are based on eligible educational debt at the start date of the LRP contract. The NIH will repay 25 percent of the eligible education debt, up to a maximum of \$50,000 per year. Loan repayment through this program is considered taxable income. Thus, the NIH makes tax payments directly to awardees' IRS tax accounts at the rate of 39 percent of the loan repayment amounts.

Veterans Affairs Education Debt Reduction Program

In the Consolidated Appropriations Act, 2023, increased funding for debt reduction awards was allocated under the Department of Veterans Affairs Educational Debt Reduction Program to be used to recruit mental health professionals to the Department of Veterans Affairs in disciplines that include psychiatry.

State loan forgiveness and repayment programs

Alaska

Alaska's SHARP Program is a public-private partnership whose goal is to improve the recruitment, retention, and distribution of health professionals in Alaska through education loan repayment or direct incentive. Half of the SHARP-1 program is funded by HRSA and half by non-federal sources including the state general fund, the Alaska Mental Health Trust Authority, and employer matches. SHARP-1 provides loan repayment for licensed primary care physicians (family clinicians, internists, pediatricians, obstetrician and gynecologists, geriatricians, and general psychiatrists) providing service in federally designated HPSAs in exchange for a two-year service obligation. The award amount is \$35,000 per year and \$47,000 per year in very hard-to-fill positions.

SHARP-3 was created by unanimous legislative passage of SB-93 in 2019 and provides loan repayment through direct incentives for providers serving individuals who are underserved, in HPSAs or in rural areas. The service contract is three-years and allows for repayment of up to \$47,250 for full-time, very hard-to-fill positions, or \$35,000 for full-time regular-fill positions. There are varying amounts for part time employment also available. Applications are accepted on a monthly basis.

Arizona

The Arizona State Loan Repayment Programs are administered by the Arizona Department of Health Services (ADHS), Bureau of Women's and Children's Health and includes the Primary Care Provider Loan Repayment Program (PCPLRP) and the Rural Private

Primary Care Provider Loan Repayment Program (RPPCPLRP). Loan repayment under these programs is in addition to a compensation package provided by the employer and is considered tax-exempt. Service obligation is a minimum of two years.

The PCPLRP program provides repayment for primary care providers employed with a public, non-profit entity located and providing services in a federally designated health professional shortage area. The RPPCPLRP is for primary care providers employed by rural private primary care practices located in federally designated health professional shortage areas. Awards for these programs vary based on HPSA Score, length of contract, and full or part-time status, but can be up to \$65,000 for an initial two-year commitment.

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. Awardees must maintain a patient caseload of 30 percent 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.

California also administers the California State Loan Repayment Program (SLRP). Eligible physicians include family medicine, general internal medicine, general pediatrics, gerontology, obstetrics/gynecology, and psychiatry specialties. Participants commit to providing a 2-year service obligation in a federally designated California Health Professional Shortage Area and will receive up to \$50,000 in repayment. Service obligation can be extended to continue to receive funding.

Colorado

The Colorado Health Service Corps provides awards up to \$120,000 for primary care providers working in designated HPSAs in exchange for a 3-year service obligation. Physicians must meet an hourly requirement throughout the service obligation providing direct patient care defined as a face-to-face/one-on-one encounter between the patient and clinician providing medically necessary or preventative care, consultation with the care team, medication management, referral and follow up.

Delaware

Delaware State Loan Repayment Program is jointly administered by the Delaware Health Care Commission, the Delaware Higher Education Office, the Division of Public Health, and the Division of Substance Abuse and Mental Health. This program awards up to \$100,000 to primary care physicians (family medicine, internal medicine, pediatrics, obstetrics/gynecology, geriatrics, and psychiatry) who work in HPSAs full-time at a qualifying practice site for a two-year service obligation.

District of Columbia

The District of Columbia provides loan repayment to eligible health professionals practicing full-time at PHLRP-certified sites in health professional shortage and medically underserved areas in DC and provides loan repayment of up to \$151,841.29 over four years.

Georgia

The Georgia Board of Health Care Workforce has several programs that assist in repaying student debt in exchange for physicians who agree to practice full-time in an underserved, rural county in Georgia with a population of 50,000 or less. These programs include the Physicians for Rural Areas Assistance Program (PRAA) and the Georgia Physician Loan Repayment Program (GPLRP).

Physicians for Rural Areas Assistance Program awards up to \$25,000 yearly for a maximum of \$100,000 to physicians who agree to practice medicine full-time in a rural county in Georgia. Contracts are awarded for one year and are renewable for an additional three years. Georgia Physician Loan Repayment Program awards up to \$25,000 per year to physicians practicing in the specialties of family medicine, internal medicine, pediatrics, obstetrics/gynecology, geriatrics, or

psychiatry for a two-year contract. Recipients can renew up to two times for a maximum of four years and \$100,000.

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, who agree to work in a federally designated health professional shortage area or an area of Hawaii found to be underserved for a minimum of two-years. The loan repayment program is tax-exempt and renewable yearly with no maximum limit to years of service.

Idaho

The Idaho Department of Health & Welfare administers the State Loan Repayment Program (SLRP) and the Rural Physician Incentive Program (RPIP). The SLRP provides loan repayment through a federal grant for physicians working in federally designated HPSAs at participating sites. Recipients may receive loan repayment awards up to \$25,000 per year with a two-year, full-time service obligation.

The RPIP is funded by fees assessed to students attending the University of Washington and University of Utah medical schools in state-supported seats. Physicians may receive a maximum of \$100,000 over a four-year period toward their academic debt. Preference is given to eligible physicians who paid into the RPIP fund and award decisions are made by the Health Care Access and Physician Incentive Grant Review Board.

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).

Kansas

The Kansas State Loan Repayment Program is administered by the Kansas Department of Health and Environment (KDHE), Office of Primary Care and Rural Health and is jointly funded by KDHE and the National Health Service Corps. Funds awarded through this program are exempt from gross income and employment taxes. Eligible physicians include those in family medicine, geriatrics, internal medicine (excluding

hospitalists), obstetrics/gynecology, pediatrics, and psychiatry practicing in a HPSA with a designation below the national NHSC Loan Repayment Program threshold. Awardees may receive up to \$25,000 per year for the initial two-year service obligation for repayment of eligible outstanding educational debt. Contracts may be extended in one-year increments for up to three additional years of service.

The Kansas Bridging Plan (KBP) is a loan forgiveness program administered by the University of Kansas Medical Center, Rural Health Education & Services (RHES) for primary care and psychiatric resident physicians in Kansas created to encourage physicians to practice in Kansas upon completion of their residency training. Each year the state of Kansas funds up to 14 slots for primary care and three slots for psychiatry. Matching funds from the state and a Kansas health care organization can provide a combined financial incentive of at least \$26,000 in exchange for a 36-month commitment to practice in an eligible Kansas County.

Kentucky

The Kentucky State Loan Repayment Program (KSLRP) is based on a 50/50 match with every dollar provided by the KSLRP having a 1:1 match from a sponsor source including employers at the practice site, private foundations, corporations, community organizations, and/or philanthropies, and rurally oriented organizations requesting that their funds be used to support the placement of practitioners in rural areas. The commitment is two-years with a maximum amount of \$100,000 to be awarded. Additionally, new in 2022, the Kentucky Behavioral Health Workforce Initiative will competitively award psychiatrists approximately 25 percent of the total Kentucky State Loan Repayment funding.

Louisiana

The Louisiana State Loan Forgiveness Program awards physicians working in a HPSA up to \$30,000 annually for a three-year initial commitment and may extend their commitment with a two-year renewal to receive \$15,000 annually.

Massachusetts

The Massachusetts Loan Repayment Program for Health Professionals is run by the Massachusetts Department of Public Health. Applicants commit to practice two years full-time providing services in an eligible underserved community. Physicians are eligible for up to \$50,000 for a two-year contract.

Michigan

The Michigan State Loan Repayment Program awards physicians providing full-time primary health care services in HPSAs, at not-for-profit health clinics, for two years, up to \$300,000 in tax-free funds to repay their educational debt over a period of up to ten years.

Minnesota

The Minnesota Rural Physician Loan Forgiveness Program awards physicians who are Primary Care Physicians (including family medicine and internal medicine physicians), Pediatricians, Psychiatrists or OB/GYNs \$33,000 per year for a service obligation of three years in a designated rural area as defined by the state. The maximum award is not to exceed \$132,000 over a four-year period.

The Minnesota Urban Physician Loan Forgiveness Program is similar to the Rural Physician Loan Forgiveness Program, but eligible physicians must serve in an urban Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA). The service obligation and maximum awards are the same for both programs.

Missouri

Missouri Health Professional State Loan Repayment Program is run by the Missouri Department of Health & Senior Services with grant money from NHSC. Applicants commit to practice two years full-time providing services in an eligible underserved community. Physicians are eligible for up to \$50,000 for a two-year contract.

Montana

The Montana Rural Physician Incentive Program (MRPIP) was authorized by the 1991 Montana Legislature and amended in 1997, 2007, and 2017 and is funded by fees assessed to Montana medical and osteopathic medical students participating in the WICHE and WWAMI medical education programs. Awardees are physicians who practice in rural or medically underserved areas of the state, or who specifically serve underserved populations.

MRPIP loan repayment disbursements are paid directly to the participants' lender or loan servicer and are distributed in six-month intervals based on a graduated payment schedule, based on how much time has been served, over the five years. Eligibility for each disbursement requires completion of the full, consecutive, six-month practice period.

MRPIP applicants are expected to continue to apply for federal NHSC loan repayment if practicing in a qualified area/location and communicate if an applicant receives any form of loan repayment through their employer or supporting institution. If an applicant/participant is currently receiving employer/supporting institution loan repayment benefits, an individual can qualify to receive MRPIP loan repayment concurrently at an adjusted award amount. Alternatively, if an individual has a high amount of outstanding debt, they could defer applying to MRPIP until they have fully exhausted their employer/supporting institution loan repayment benefit, and then apply to MRPIP for the full award amount. The maximum amount of debt repayment a full-time physician may receive is \$150,000 over a 5-year period of verified medical service.

Nebraska

The Nebraska State Loan Repayment Program has a maximum award amount for \$60,000 per year for three years of service in a HPSA. Eligible specialties depend on the need of a specific area, but include Family Medicine, Internal Medicine, General Pediatrics, OB/GYN, General Surgery, Child and Adolescent Psychiatry, and General Psychiatry. Funding for the awards is provided by a state and local partnership with award amounts supplied 50 percent by the state and 50 percent by the local community. The Rural Health Advisory Commission determined in 2019 that ER time would be allowable for State Loan Repayment Recipients. Up to 50 percent telehealth is allowable for the State Program as well, provided all other requirements are met. Call time is not counted as part of the calculation of hours worked. These loan repayment funds are not taxable as income.

New Hampshire

The New Hampshire State Loan Repayment Program (SLRP) is administered by the Division of Public Health Services (DPHS), Rural Health & Primary Care Section (RHPC) and provides funds to primary care physicians working in areas of the state designated as being medically underserved and who are willing to commit and contract with the state for a minimum of three years (or two if part-time). The allotment of funds is contingent on the availability of specified SLRP funding in the State budget for any given fiscal year and are up to or \$75,000 for a minimum service obligation of 36 months with an opportunity of an extension for an additional 24 months at \$40,000.

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 with awards up to \$35,000 annually, contingent on state appropriations. Eligible specialties are primary care physicians (to include an allopathic or osteopathic physician with a specialty in family or general medicine, general internal medicine, general pediatrics, and obstetrics and gynecology and other specialties as may be considered at the discretion of the department). Priority is given to those applicants working in designated areas of greatest need.

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 practicing in physician shortage areas.

North Carolina

The North Carolina Office of Rural Health administers the North Carolina State Loan Repayment Program (SLRP). The Office of Rural Health Placement team works to identify opportunities for psychiatrists to practice in an integrated care setting that matches the providers personal and professional needs with community needs. These integrated care opportunities are in a variety of practice settings including Federal Community Health Centers (also known as Federally Qualified Health Centers, or FQHCs), State-Sponsored Rural Health Centers, County Health Departments, State Mental Health Hospitals, Alcohol and Drug Abuse Treatment Centers, Community Mental Health Facilities, and others.

Based on the amount of relevant educational loans, hours worked per week, and working at an integrated care site, SLRP offers educational loan repayment awards up to \$50,000 for psychiatrists. The awards are not

taxable and granted in exchange for a three-year service commitment in a team-based setting that provides comprehensive behavioral health services to rural communities with a Health Professional Shortage Area.

Oklahoma

Funds from Oklahoma's Tobacco Settlement Endowment Trust are used to provide grants to the Physician Manpower Training Commission, which grants up to \$200,000 in loan repayment for primary care physicians in the program who practice up to four years in a medically underserved or rural area. Primary care includes family medicine, geriatrics, general internal medicine, general pediatrics, obstetrics/gynecology, or emergency medicine. General surgery as an eligible specialty is pending.

Oregon

The 2017 Oregon Legislature approved HB 3261, establishing the Healthcare Provider Incentives Program within the Oregon Health Authority (OHA) to support access to care for underserved communities throughout Oregon. The Program offers various incentives, which include loan repayment, loan forgiveness, and insurance subsidies to both students and providers who commit to serving patients in underserved areas of the state.

The Oregon Health Care Provider Loan Repayment program requires that full-time service providers commit to a 3-year minimum service obligation in exchange for a tax-free award of 50 percent of their qualifying loan debt balance, up to \$35,000 per obligation year. Part-time service providers must commit to a 3-year minimum service obligation in exchange for a tax-free award of 25 percent of their qualifying loan debt balance, up to \$25,000 per obligation year. Depending on availability of funds award continuations of up to 9 total award years may be possible.

Pennsylvania

The Pennsylvania Primary Care Loan Repayment Program is administered by the Pennsylvania Department of Health and provides award amounts up to \$80,000 (full-time) and up to \$40,000 (half-time) to primary care physicians who work in designated Health Professional Shortage Areas or serve a minimum of 30 percent low-income patients for a two-year service commitment. Primary care is defined as the following specialties: Family Medicine, General Internal Medicine, General Pediatrics, Geriatrics, Obstetrics/Gynecology, or Psychiatry.

Rhode Island

The Stay Invested in RI Wavemaker Fellowship Fund is a public-private partnership administered by the Wavemaker Rhode Island Commerce Corporation. Fellows can receive annual refundable tax credits for up to four years equal to the Fellow's annual loan repayment expenses up to \$6,000. The credit can be applied against Rhode Island income tax or redeemed for the cash equivalent. Refunds of the tax credit may be subject to federal income tax.

Additionally, the State of Rhode Island Department of Health administers the Health Professional Loan Repayment Program. Award recipients must make a two-year commitment to provide direct patient care in an ambulatory outpatient setting at eligible sites caring for underserved patients. Award amounts can be up to \$50,000 and vary based on income and student loan balances for an initial two year term.

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 by a primary care physician (defined as Family Medicine, General Internal Medicine, Pediatrics, Obstetrics/Gynecology, or Geriatrics physicians).

Texas

The Physician Education Loan Repayment Program (PELRP), administered by the Texas Higher Education Coordinating Board, provides loan repayment to primary care physicians in exchange for a commitment to practice in a Health Professional Shortage Area in an outpatient setting for at least four years and an agreement to provide care to CHIP and Medicaid patients. The total award amount is contingent on student loan amount and availability of funding but is up to \$180,000.

Utah

The Rural Physician Loan Repayment Program (RPLRP) is administered by the Utah Department of Health and Human Services, Primary Care and Rural Health. The RPLRP awards up to \$20,000 per contract year to nine providers in primary care, OB/GYN, general surgery, orthopedic surgery, pediatrics, and internal medicine throughout rural Utah hospitals for a minimum of two years of service.

Utah also has the Health Care Workforce Financial Assistance Program which is a combination of Utah's Behavioral Health Workforce Reinvestment Initiative and Health Care Workforce Loan Repayment Programs. The Financial Assistance Program is a state-local partnership with physician's sites matching 20 percent of the funds providing up to \$75,000 total in loan repayment to physicians working in a HPSA in exchange for a three-year service commitment. This student loan repayment is tax-free.

Vermont

The Vermont Educational Loan Repayment Program for Health Care Professionals is funded by federal and state funds and is administered by the UVM Larner College of Medicine Office of Primary Care and Area Health Education Centers (AHEC) Program and provides loan repayment for physicians serving in underserved communities. Program eligibility, award amount, and selection criteria change annually.

Virginia

The Virginia State Loan Repayment Program awards a maximum amount of to \$100,000 for the minimum service obligation of two-years to primary care physicians working at an eligible site. Funds are from federal, state, and local sources and the award is renewable annually up to a maximum of four-years with a maximum award of \$140,000.

Washington

Washington Health Corps was established by the 2019 Legislature as an umbrella under which the State Health Program (SHP) continued, and a new Behavioral Health Program (BHP) was created as a federal grant-state match program. Since 1990, the programs have helped to recruit and retain over 1,500 providers throughout Washington State. The Washington Health Corps Program awards up to \$75,000 for three-years of service for primary care physicians.

West Virginia

The West Virginia State Loan Repayment Program provides primary care physicians working in HPSAs \$40,000 for an initial two-year commitment and \$25,000/year for an additional two-year commitment with a maximum four years of funding (\$90,000 total).

Wisconsin

The Wisconsin Office of Rural Health administers two loan assistance programs: the Health Professions Loan Assistance Program (HPLAP) and the Rural Provider Loan Assistance Program (RPLAP). The HPLAP awards up to \$50,000 in education loan assistance to physicians practicing in an outpatient setting in federally-designated HPSAs in exchange for three years of service. Wisconsin primary care physicians and psychiatrists practicing in an outpatient setting in a rural community (whether or not it is designated as an HPSA) are also eligible for the RPLAP with a maximum award of up to \$50,000.

Wyoming

The Wyoming Healthcare Professional Loan Repayment Program was created during the 2005 legislative session and provides awards up to \$50,000 per year for primary care physicians in federally designated HPSAs.

Underrepresented in medicine funding opportunities

Rising medical school debt disproportionately impacts students who are low income.^{cxvii} Due to the cost of medical school many low-income individuals are completely deterred from attending medical school in the first place. According to a national survey, the cost of attending medical school was the number one reason why qualified applicants chose not to apply. Additional surveys by the Association of American Medical Colleges (AAMC) support this conclusion and found that minorities from underrepresented communities cited cost of attendance as the top deterrent to applying to medical school.

Several studies have shown that students from underrepresented groups are more likely than whites to provide health care services in underserved communities. For example, a 2012 study of California physicians found that, regardless of specialty, African American, Latino, and Pacific Islander physicians were more likely to practice in underserved or health shortage areas than their white counterparts. In certain specialties, Asian physicians were also more likely to serve in underserved areas than their white counterparts.^{cxviii} Since minority students are also more likely to enter primary care than their white colleagues, the immense debt burden of medical school has precluded diversity among physicians, limited the potential number of primary care physicians, and diminished the number of physicians who are most likely to work in underserved communities. Thus, with

recent health reforms seeking to eliminate health care disparities amongst the U.S. population, increasing the number of physicians from historically underrepresented communities is important to ensuring a health care workforce that is more reflective of the general population. Several funding opportunities have been created to help increase the number of residents from underrepresented groups either through funding to residents or to medical students from diverse backgrounds. Following is a sample of some of these programs.

Health Resources Services Administration (HRSA) Scholarships for Disadvantaged Students (SDS)

HRSA grants funding to schools for the administration of SDS to their students. Funding does not go directly to students. To qualify, at least 20 percent of the school's full-time enrolled students and graduates must be from disadvantaged backgrounds, in the most recent three-year period. These schools must be carrying out a program to recruit and retain students from disadvantaged backgrounds, including racial and ethnic minority groups. The SDS program has a cap of \$40,000 per student, per academic year.

American Medical Association Foundation Scholarships

The AMA has several scholarships available to students through the AMA Foundation for rising final-year medical students. These include the following:

- Underrepresented in Medicine scholarship (\$10,000) for students who are African American/Black, Latinx/Hispanic, or Indigenous (Native American, Hawaiian, or Alaska Native) who demonstrate a dedication to serving vulnerable or underserved populations
- David Jones Peck, MD Scholarship for Health Equity (\$10,000) for students who demonstrate a commitment to addressing health disparities and promoting health equity in marginalized and minoritized communities
- Dr. Richard Allen Williams & Genita Evangelista Johnson/Association of Black Cardiologists (\$5,000) for an African American/Black student with an interest in Cardiology
- DREAM MD Equity Scholarship (\$10,000) awarded to a medical student beneficiary of the Deferred Action for Childhood Arrivals (DACA) program, and/or first-generation immigrant to the United States who has a demonstrated history of public advocacy for the equitable treatment of immigrants.

American Medical Association and the Satcher Health Leadership Institute (SHLI) at Morehouse School of Medicine Medical Justice in Advocacy Fellowship

The Medical Justice in Advocacy Fellowship is a collaborative educational initiative to empower physician-led advocacy that advances equity and removes barriers to optimal health for marginalized people and communities. Participating fellows will receive a stipend of \$15,000 for their participation in the program and would be eligible for up to 28 CME credit hours.

Indian Health Service Scholarship

The Indian Health Service provides scholarships covering tuition along with a monthly stipend to cover living expenses to members of a federally recognized American Indian Tribe or Alaska Native Village in allopathic and osteopathic medical schools. Recipients of the scholarship are required to complete a minimum of two years of service at an approved IHS site with one year of services per year of support received, thereafter.

Alternative routes for medical students who fail to match

According to the National Resident Matching Program[®], in 2022, there were 36,277 PGY-1 positions offered with 42,549 applicants for those positions. This led to 6,272 applicants not obtaining a position. The PGY-1 match rate for U.S. MD seniors was 92.9 percent. Historically, the PGY-1 match rate for U.S. MD seniors has been 92-95 percent. The PGY-1 match rate for U.S. DO seniors in 2022 was 91.3 percent, up 2.2 percentage points from 2021. Of the 5,048 U.S. IMGs who submitted rank order lists of programs, 3,099 matched to a PGY-1 position for a match rate of 61.4 percent. Of the 7,864 non-U.S. citizen IMGs who submitted rank order lists of programs, 4,571 matched to a PGY-1 position for a match rate of 58.1 percent.^{cxxxiv}

Among all matched U.S. MD seniors, 48.5 percent matched to their first-choice programs (an increase of 2.1 percentage points over 2021); 74.5 percent of U.S. MD seniors matched to one of their top three choices (an increase of 2.2 percentage points over 2021). Among all matched U.S. DO seniors, 47.7 percent matched to their first-choice programs (an increase of 5.3 percentage points over 2021); 76.7 percent matched to one of their top three choices (an increase of 4.5 percentage points over 2021).^{cxxxv}

Supplemental Offer and Acceptance Program[®]

The Supplemental Offer and Acceptance Program[®] (SOAP[®]) is the process by which eligible unmatched, or partially unmatched applicants may apply to programs with unfilled residency positions and receive offers through the National Resident Matching Program[®] (NRMP[®]) Registration, Ranking, and Results (R3[®]) system.^{cxxxvi} Students are able to apply to a total of 45 Match participating programs which can include reapplications to programs that students already applied to as well as new programs, as long as the program is participating in SOAP and has unfilled positions that the applicant is eligible for.

In 2022, there were 2,262 positions placed in the Match Week SOAP. There were 99 SOAP-participating programs with 151 positions unfilled at the conclusion of SOAP.^{cxxxvii}

Assistant Physician

Several states have created the position of an “Assistant Physician” for students who have completed medical school, but have not matched into a residency. For example, Missouri, Arkansas, Kansas, Utah, and Arizona have enacted assistant physician legislation.^{cxxxviii} AMA policy H-160.949 opposes special licensing pathways for “assistant physicians” which the AMA defines as those who are not currently enrolled in an Accreditation Council for Graduate Medical Education training program, or have not completed at least one year of accredited graduate medical education in the U.S. due to concerns that residents will not be adequately protected and may not receive the training necessary to be successful in future Match application cycles.^{cxxxix}

“5th Year” research + clinical programs for unmatched graduates

Medical schools can create their own internal tracks for unmatched students to enter post medical school that enable them to stay competitive for the next year’s Match by allowing them to do a mix of research and supplemental clinical rotations, like a 5th year of medical school.

During this time, students can also take the United States Medical Licensing Examination[®] (USMLE[®]) Step 3, the last exam by the USMLE before physicians can assume independent responsibility for delivering general medical care. Students who have passed Step 1 and Step 2 CK, and have an MD or DO degree from

an LCME- or COCA- accredited US or Canadian medical school, or the equivalent of the MD degree from a medical school outside the US and Canada that is listed in the *World Directory of Medical Schools* as meeting ECFMG eligibility requirements and obtain ECFMG Certification, are eligible to take the exam whether or not they are in a residency program. Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) Level 3, however, requires that an individual is currently a resident to be eligible to sit for the exam.^{cxl} Taking Step 3 prior to re-applying for the Match allows students to take the exam while the knowledge is still fresh and can make them a more competitive applicant when they re-apply. However, the USMLE program recommends that students taking Step 3 complete, or are near completion of, at least one postgraduate training year in an accredited US graduate medical education program that meets state board licensing requirements.^{cxli}

Master's programs for non-matched medical students

Medical schools could develop relationships with various masters' programs to funnel non-matching students into. Opportunities of this approach include students staying engaged in the learning environment and if students do not Match in subsequent years, they are more competitive in the job market with an MD/DO and a master's degree. However, challenges include students taking on additional debt from another year of schooling without the guarantee of Matching in the next application cycle and having no ability to build clinical skills. Additionally, it is unclear how to incentivize universities to take MD/DO students after masters' programs have already accepted their new class (as application timelines do not align with Match results). It is also unclear to what degree students are actually more competitive applicants for the Match.

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>

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

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

It is AMA policy that:

- A. Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public.
- B. Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving

and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved.

- C. Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding.
- D. Diversified sources of funding should be available to support medical schools’ multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school’s missions.
- E. All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding.
- F. Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage.
- G. Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training.
- H. Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs.
 1. New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties.
 2. Our AMA endorses the following principles of social accountability and promotes their application to GME funding: (a) Adequate and diverse workforce development; (b) Primary care and specialty practice workforce distribution; (c) Geographic workforce

- distribution; and (d) Service to the local community and the public at large.
3. Our AMA encourages transparency of GME funding through models that are both feasible and fair for training sites, affiliated medical schools and trainees.
 4. Our AMA believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publically report the aggregate value of GME payments received as well as what these payments are used for, including:
 - (a) Resident salary and benefits;
 - (b) Administrative support for graduate medical education;
 - (c) Salary reimbursement for teaching staff;
 - (d) Direct educational costs for residents and fellows; and
 - (e) Institutional overhead.
 5. Our AMA supports specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty.

CME Rep. 7, A-05Reaffirmation I-06Reaffirmed: Sub. Res. 314, A-07Reaffirmation I-07Reaffirmed: CME Rep. 4, I-08Reaffirmed: Sub. Res. 314, A-09Reaffirmed: CME Rep. 3, I-09Reaffirmed: CME Rep. 15, A-10Reaffirmation A-11Reaffirmation A-13Reaffirmed: CME Rep. 5, A-13Appended: CME 05, A-16Appended: Res. 319, A-16Reaffirmation A-16

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

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that

is subject to instability and uncertainty.

6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA:
 - (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed;
 - (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and
 - (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation’s current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for

Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution. 15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site. 16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability. 17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region. 18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes. 19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce. 20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education. 21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education. 22. Our AMA will advocate for the appropriation of Congressional funding in support of the National

Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation. 23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME. 24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing. 25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs. 26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME. 27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future. 28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services. 29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows. 30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding. 31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas. 32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance

plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion. 33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs. 34. Our AMA will publicize best practice examples of state-funded Graduate Medical Education positions and develop model state legislation where appropriate.

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 Reaffirmed: CME Rep. 3, A-21 Appended: Res. 202, I-22

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 Reaffirmation: I-22

H-305.925, "Principles of and Actions to Address Medical Education Costs and Student Debt"

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.

4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit:
 - (a) inclusion of all medical specialties in need, and
 - (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100percent tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to
 - (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education;
 - (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs;
 - (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students;
 - (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students;
 - (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation;
 - (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen;
 - (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees;
 - (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies;
 - (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals:
 - (a) Eliminating the single holder rule;
 - (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training;
 - (c) Retaining the option of loan forbearance for residents ineligible for loan deferment;
 - (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”;
 - (e) Including room and board expenses in the definition of tax-exempt scholarship income;
 - (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal

- loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.
15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
 16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short- and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
 17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
 18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
 19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
 20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status; (f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes; (j) Monitor the denial rates for physician applicants to the PSLF; (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program; (l) Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; and (m) Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).
 21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.

CME Report 05, I-18Appended: Res. 953, I-18Reaffirmation: A-19Appended: Res. 316, A-19Appended: Res. 226, A-21Reaffirmed in lieu of: Res. 311, A-21Modified: CME Rep. 4, I-21Reaffirmation: A-22

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.
3. Our AMA will advocate to appropriate federal agencies, and other relevant stakeholders to oppose the diversion of direct and indirect funding away from ACGME-accredited graduate medical education programs.

Sub. Res. 913, I-09 Appended: Res. 917, I-15 Appended: Res. 309, I-20Reaffirmed: Res. 305, A-21

H-310.904, “Graduate Medical Education and the Corporate Practice of Medicine”

Our AMA: (1) recognizes and supports that the environment for education of residents and fellows must be free of the conflict of interest created between a training site’s fiduciary responsibility to shareholders and the educational mission of residency or fellowship training programs; (2) encourages the Accreditation Council for Graduate Medical Education (ACGME) to update its “Principles to Guide the Relationship between Graduate Medical Education, Industry, and Other Funding Sources for Programs and Sponsoring Institutions Accredited by the ACGME” to include corporate-owned lay entity funding sources; and (3) will continue to monitor issues, including waiver of due process requirements, created by corporate control of graduate medical education sites.

Res. 303, A-19Modified: CME Rep. 2, I-20Reaffirmed: CME Rep. 01, I-22

H-310.901, “The Impact of Private Equity on Medical Training H-310.901”

Our AMA will:

1. Affirm that an institution or medical education training program academic mission should not be compromised by a clinical training site’s fiduciary responsibilities to an external corporate or for-profit entity.
2. Encourage GME training institutions, programs, and relevant stakeholders to:
 - a. demonstrate transparency on mergers and closures, especially as it relates to private equity acquisition of GME programs and institutions, and demonstrate institutional accountability

- to their trainees by making this information available to current and prospective trainees;
 - b. uphold comprehensive policies which protect trainees, including those who are not funded by Medicare dollars, to ensure the obligatory transfer of funds after institution closure;
 - c. empower designated institutional officials (DIOs) to be involved in institutional decision-making to advance such transparency and accountability in protection of their residents, fellows, and physician faculty;
 - d. develop educational materials that can help trainees better understand the business of medicine, especially at the practice, institution, and corporate levels;
 - e. develop policies highlighting the procedures and responsibilities of sponsoring institutions regarding the unanticipated catastrophic loss of faculty or clinical training sites and make these policies available to current and prospective GME learners.
3. Encourage necessary changes in Public Service Loan Forgiveness Program (PSLF) to allow medical students and physicians to enroll in the program even if they receive some or all of their training at a for-profit or governmental institution.
 4. Support publicly funded independent research on the impact that private equity has on graduate medical education.
 5. Encourage physician associations, boards, and societies to draft policy or release their own issue statements on private equity to heighten awareness among the physician community.
 6. Encourage physicians who are contemplating corporate investor partnerships to consider the ongoing education and welfare for trainee physicians who train under physicians in that practice, including the financial implications of existing funding that is used to support that training.

CME Rep. 01, I-22

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

H-200.949, “Principles of and Actions to Address Primary Care Workforce”

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation’s current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields;

- and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
 4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
 5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
 6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
 7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
 8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
 9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
 10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
 11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
 12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
 13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that

- promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
 15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
 16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
 17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
 18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
 19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
 20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
 21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
 22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
 23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
 24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
 25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.

CME Rep. 04, I-18

H-160.949, “Practicing Medicine by Non-Physicians”

Our AMA:

- (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;
- (2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers;
- (3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;
- (4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;
- (5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine; and
- (6) opposes special licensing pathways for “assistant physicians” (i.e., those who are not currently enrolled in an Accreditation Council for Graduate Medical Education training program, or have not completed at least one year of accredited graduate medical education in the U.S).

Policy Timeline

Res. 317, I-94Modified by Res. 501, A-97Appended:
Res. 321, I-98Reaffirmation A-99Appended: Res. 240,
Reaffirmed: Res. 708 and Reaffirmation A-00Reaffirmed:
CME Rep. 1, I-00Reaffirmed: CMS Rep. 6, A-10Reaffirmed:
Res. 208, I-10Reaffirmed: Res. 224, A-11Reaffirmed: BOT
Rep. 9, I-11Reaffirmed: Res. 107, A-14Appended: Res.
324, A-14Modified: CME Rep. 2, A-21

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-350.960, “Underrepresented Student Access to US Medical Schools”

Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students; (3) recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination; (4) is committed to promoting truth and reconciliation in medical education as it relates to improving equity; (5) recognizes the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations; (6) will urge medical schools to develop or expand the reach of existing pathway programs for underrepresented middle school, high school and college aged students to motivate them to pursue and prepare them for a career in medicine; (7) will encourage collegiate programs to establish criteria by which completion of such programs will secure an interview for admission to the sponsoring medical school; (8) will recommend that medical school pathway programs for underrepresented students be free-of-charge or provide financial support with need-based scholarships and grants; (9) will encourage all physicians to actively participate in programs and mentorship opportunities that help expose underrepresented students to potential careers in medicine; and (10) will consider quality of K-12 education a social determinant of health and thus

advocate for implementation of Policy H-350.979, (1) (a) encouraging state and local governments to make quality elementary and secondary education available to all.

Policy Timeline

Res. 908, I-08Reaffirmed in lieu of Res. 311, A-15Appended: CME Rep. 5, A-21Appended: Res. 305, I-22

H-310.919, “Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process”

Our AMA:

1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;
2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;
3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;
4. encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and
5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs.

Policy Timeline

Res. 307, A-09Appended: Res. 955, I-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

D-310.992, “Limits on Training Opportunities for J-1 Residents”

Our AMA will request that the Bureau of Educational and Cultural Affairs, Accreditation Council for Graduate Medical Education (ACGME), American Board of Medical Specialties and the Educational Commission for Foreign Medical Graduates develop criteria by which J-1 exchange visitor physicians could seek extension of the length of their visa beyond the 7-year limit in order to participate in fellowship or subspecialty programs accredited by the ACGME.

Res. 303, A-01 Reaffirmed: CME Rep. 2, A-11 Reaffirmation A-14

D-310.946, “The Effect of the COVID-19 Pandemic on Graduate Medical Education”

Our AMA will: (1) work with relevant stakeholders to advocate for equitable compensation and benefits for residents and fellows who are redeployed to fulfill service needs that may be outside the scope of their specialty training; and (2) urge the Accreditation Council for Graduate Medical Education (ACGME) and specialty boards to consider reducing case numbers and clinic visits with revised holistic measures to recognize resident/fellow learning, given the drastic educational barriers confronted during the COVID-19 pandemic.

Res. 319, A-21

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