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3 Title: Preserve and Increase Graduate Medical Education Funding  
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5 Introduced by: David Whalen, MD, for the Kent County Delegation  
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7 Original Author: Jayne E. Courts, MD, FACP  
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9 Referred To: Reference Committee D  
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11 House Action: APPROVED  
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14 Whereas, the U.S. General Accountability Office (GAO) recently announced their fiscal year  
15 budget, and

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17 Whereas, their announcement included information about potential changes in graduate  
18 medical education (GME) funding, and

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20 Whereas, the GAO released a report in December 2019, entitled, "Views on Expanding  
21 Medicare Graduate Medical Education Funding to Nurse Practitioners and Physician Assistants,"  
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24 Whereas, this report contains potential errors that may adversely influence legislative  
25 decisions, and

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27 Whereas, GME funding, direct and indirect funding, has been earmarked for resident  
28 physicians to support their education and training in teaching hospitals, and

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30 Whereas, advanced practice professionals, such as nurse practitioners or physician  
31 assistants, have a shorter training period with an associated lower overall cost for the trainee and  
32 no requirement for a residency, and

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34 Whereas, the number of residency slots has not been increased for most residency  
35 programs since 1997 due to the restrictions imposed by the Balanced Budget Act, and

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37 Whereas, teaching hospitals rely on GME funding to offset the increased cost of providing  
38 care that may occur in a teaching hospital setting due to the presence of additional health care  
39 personnel who are trainees, and

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41 Whereas, an increase in GME funding has been an ongoing request to our legislators for the  
42 past few years due to concerns about the rising expenses of providing education coupled with the  
43 stagnation of GME funding, and

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45 Whereas, the United States is facing a significant and severe physician shortage based on  
46 current predictors and estimates, and

47           Whereas, the diversion of GME funding to non-physicians will only make this situation  
48 worse with potential serious consequences for the health of our nation due to lack of physician  
49 access; therefore be it

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51           RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask  
52 our AMA to work with the Liaison Committee on Medical Education, the Accreditation Council for  
53 Graduate Medical Education, and other interested stakeholders to encourage the U.S. Government  
54 Accountability Office to oppose and refrain from further consideration of the diversion of direct  
55 and indirect graduate medical education funding to non-physicians.  
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58 WAYS AND MEANS COMMITTEE FISCAL NOTE: \$12,000-\$24,000 for regulatory advocacy.

**Relevant MSMS Policy:**

**Adopting Alternative Sources of Graduate Medical Education Funding**

MSMS supports the principle or concept of an all-payer fund that would distribute the cost of training physicians across Medicare, Medicaid, and private health insurance plans.

**Increasing Post-Graduate Medical Education Slots in the State of Michigan**

MSMS supports increased funding from private and federal sources for post-graduate residency training in the state of Michigan.

**Increase Funding for Post-Graduate Education**

MSMS supports increased federal funding for post graduate medical education, nationwide.

**Increasing Residency Slots for Post-Graduate Medical**

Education in the State of Michigan MSMS encourages the American Medical Association, American Counsel of Graduate Medical Education (ACGME), federal government, and financially supporting hospital(s) and institution(s) to increase residency positions for qualified American and International medical graduates in the state of Michigan.

**Medicaid Funding for Graduate Medical Education**

MSMS supports increased funding for graduate medical education by Medicaid.

**Reform Michigan Medicaid GME Funding**

MSMS supports requiring that all Medicaid Graduate Medical Education (GME) funding to hospitals be earmarked and spent for GME purposes only; that the current GME funding be replaced with a new formula of paying hospitals and institutions for direct medical education expenses (i.e., resident salaries and benefits, faculty salaries, program support staff, and hospital overhead) for additional slots exceeding the Medicare funding cap only; and that GME funding for innovative residency programs to promote access to patient care in urban and rural areas and in specialties with limited patient access be encouraged.

**State Medicaid GME Funding for New GME Slots**

MSMS supports using current Medicaid GME funding to fund new residency slots in Michigan, and seeking extra GME funding with financial incentives provided through the Michigan Department of Community Health to programs whose graduates choose to stay in Michigan in great proportion.

**Relevant AMA Policy:**

**Funding to Support Training of the Health Care Workforce H-310.916**

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.

### **Securing Funding for Graduate Medical Education H-310.917**

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.

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

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.

**Sources:**

1. U.S. Government Accountability Office Report to Congressional Committees December 2019 HEALTH CARE WORKFORCE "Views on Expanding Medicare Graduate Medical Education Funding to Nurse Practitioners and Physician Assistants"
2. "Residency: The Bottleneck in Physician Training" Physicians for Patient Protection/PPP Response to GAO Report, on-line resource, accessed February 10, 2020.