

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 233
(A-19)

Introduced by: Georgia

Subject: GME Cap Flexibility

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, Projections by the Association of American Medical Colleges (AAMC) describe a deficit of 291,500 physicians by 2020 and 130,600¹. According to the Georgia Physician Workforce, Georgia was ranked 39th in the nation for the number of practicing physicians per 100,000 people in 2016². According to a report by the AAMC, Georgia would need to add nearly 1,500 new residency slots to match the national rate²; and

Whereas, New Graduate Medical Education teaching hospitals are allotted a five-year “cap window” allowing programs to increase the amount of residents in a program within that time frame, with the final amount of residents present in the fifth (and final) year of the “cap-building window” permanently determining the amount of funding from Medicare the program will receive, essentially “capping” Medicare funding, set by the Balanced Budget Act of 1997³; and

Whereas, Targeting support for GME programs by extending the cap-building window for new and existing teaching hospitals in rural, underserved, under- resourced communities and/or areas currently lacking medical training infrastructure will benefit our national GME system in many ways, including, but not limited to:

(a) Providing lifesaving opportunities for new teaching institutions to further develop residency programs and secure the resources necessary to launch and/or scale-up training capabilities. The additional time is vital to ensuring that teaching institutions in under resourced areas will be able to build-up to a level necessary to meet regional needs

(b) Alleviating regional physician shortages by providing time for institutions to add primary care and/or specialty and sub-specialty residencies in shortage;

(c) Boosting the return on investment for Medicare, local communities, states, medical schools, and the hosting teaching hospital.

(d) Helping address the disproportionate maldistribution of physicians and GME resources across the country³; and

Whereas, As residents tend to practice where they train, adding, developing, and incentivizing the establishment of programs at teaching institutions located in underserved, under-resourced, and rural areas will help address the current maldistribution of physicians across the country³; therefore be it

¹ Association of American Medical Colleges. The impact of health care reform on the future supply and demand for physicians updated projections through 2025. https://www.aamc.org/download/158076/data/updated_projections_through_2025.pdf. Published June 2010. Accessed January 12, 2015.

² Association of American Medical Colleges. 2016 state physician workforce data book. <https://www.aamc.org/download/484530/data/georgiaprofile.pdf>

³ Cap Flexibility: Putting GME Dollars to Work. Doctor's Hospital at Renaissance Health System , pp. 1–39, Cap Flexibility: Putting GME Dollars to Work.

1 RESOLVED, That our American Medical Association advocate for the Centers for Medicare and
 2 Medicaid Services (CMS) to adopt the concept of “Cap-Flexibility” and allow new and current
 3 Graduate Medical Education teaching institutions to extend their cap-building window for up to
 4 an additional five years beyond the current window (for a total of up to ten years), giving priority
 5 to primary care residencies (Directive to Take Action); and be it further

7 RESOLVED, That our AMA advocate for CMS to provide funding to hospitals and/or universities
 8 prior to the arrival of any residents, removing the clause where “Medicare funding does not
 9 begin until the first resident is ‘on-duty’ at the hospital.” (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 05/09/19

Additional Resources

4. Casey L., Gillanders W. R., Oprandi A. M., et al. Economic analysis of family practice residency programs: a report from the Northeastern Ohio Network. *Fam Med.* 1995;27(7):424–430. [PubMed]
5. Georgia Board for Physician Workforce. Georgia physician and physician assistant professions data book 2010/2011. https://gbpw.georgia.gov/sites/gbpw.georgia.gov/files/related_files/site_page/2010-2011%20Physician%20and%20PA%20Data%20Book-Final.pdf. Published December 2013. Accessed January 12, 2015.
6. Kahn N. B., Pugno P. A., Brown T. C. Transferring sponsorship of a family practice residency: financial implications. *Fam Med.* 1991;23(8):620–623. [PubMed]
7. Nuss, Michelle A., and Peter F. Buckley. “Journal of the Medical Association of Georgia · October 2015.” Georgia’s innovative response to GME expansion, 28 Dec. 2015, pp. 10–11., https://www.researchgate.net/publication/283898723_Georgia%27s_innovative_response_to_GME_expansion.
8. Pauwels J. Three-year trends in the costs of residency training in family medicine. *Fam Med.* 2006;38(6):408–415. [PubMed]
9. Pugno, Perry A., William Ross Gillanders, and Stanley M. Kozakowski. “The Direct, Indirect, and Intangible Benefits of Graduate Medical Education Programs to Their Sponsoring Institutions and Communities.” *Journal of Graduate Medical Education* 2.2 (2010): 154–159. PMC. Web. 7 Sept. 2017.
10. Saultz J. W., McCarty G., Cox B., Labby D., Williams R., Fields S. A. Indirect institutional revenue generated from an academic primary care clinical network. *Fam Med.* 2001;33(9):342–345. [PubMed]
11. Schneeweiss R., Ellsbury K., Hart L. G., Geyman J. P. The economic impact and multiplier effect of a family practice clinic on an academic medical center. *JAMA.* 1989;262(3):370–375. [PubMed]
12. University of Oklahoma Health Science Center. University of Oklahoma Health Science Center for Health Policy Research Report. Tulsa, OK: University of Oklahoma; 2002. Family medicine economic benefits of residency training programs.
13. Woodcock E. W. Assessing primary care’s contribution to academic health centers. *Med Group Manag J.* 1999;46(2):14–18. [PubMed]

RELEVANT AMA POLICY

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 for flexibility beyond the current maximum of five years for the Medicare graduate medical education cap-setting deadline for 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 will investigate the status of implementation of AMA Policies D-305.973, "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs" and D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education" and report back to the House of Delegates with proposed measures to resolve the problems of underfunding, inadequate number of residencies and geographic maldistribution of residencies.

Citation: 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