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February 12, 2016

The Honorable Stephen D. Newman  
Chairman  
Committee on Education and Health  
Senate of Virginia  
General Assembly Building, Room 621  
Capitol Square  
Richmond, VA 23219

Re: AMA opposition to Virginia House Bill 900

Dear Chairman Newman:

On behalf of the American Medical Association (AMA) and our physician and student members, I am writing to express the AMA's **opposition to House Bill (H.B.) 900**, which would create a new licensure category of "associate physicians," medical school graduates who have not undertaken a residency program. The AMA opposes special licensure pathways for physicians who are not currently enrolled in Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) training programs, or have not completed at least one year of accredited graduate medical education.

The AMA appreciates that the intent of this legislation is to bridge critical gaps in the health care workforce, particularly those due to limited residency positions. However, we encourage the Virginia General Assembly to pursue more practical workforce solutions, such as increasing the number of state-funded residency positions—including those positions in medically underserved areas, or pursuing ways to making existing residency programs more accessible or attractive to Virginia's medical school graduates. Examples of state efforts on these and other workforce solutions can be found in the enclosed AMA Council on Medical Education report. The AMA would be happy to support any of these efforts in Virginia.

While well meaning, H.B. 900 disregards the decades of evidence and experience behind established graduate medical education programs in the United States. Accredited residency programs are highly structured to provide a well-rounded and rigorous clinical and educational experience for medical school graduates. Traditional residency programs are based in environments that have clinical education as a core mission, with residents providing care under the supervision of physician educators. Residents are evaluated based on standardized approaches that examine the residents' knowledge base, clinical skills, and professionalism, while also identifying those in need of more training. Based on these assessments, residents are afforded progressively greater autonomy.

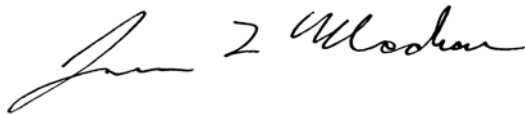
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In fact, the clear trend in graduate and continuing medical education is more evaluation and ongoing competency measures, not less. Skipping the educational and experiential training under supervision in an accredited program thus goes against both trends and proven approaches to ensuring that today's physicians are competent to enter and remain in practice.

In contrast, H.B. 900 offers no infrastructure for training or supervising associate physicians, nor does it offer standard and proven assessment tools to determine the quality of care these practitioners deliver. The legislation similarly lacks any standard for the supervising physician or expectation that the physician supervisor have experience as an educator. Moreover, it is unclear whether the experience proposed will be of value as these practitioners continue to seek placement in traditional residency programs. We thus encourage the legislature to better understand the effects of H.B. 900 on the health care workforce and patient outcomes before moving forward. For these and the above reasons, we urge you to **oppose H.B. 900**.

Thank you for the opportunity to provide our input. Please contact Kristin Schleiter, JD, Senior Legislative Attorney, at [kristin.schleiter@ama-assn.org](mailto:kristin.schleiter@ama-assn.org) or (312) 464-4783 with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "James L. Madara". The signature is fluid and cursive, with a large initial "J" and "M".

James L. Madara, MD

Enclosure

cc: Robert M. Wah, MD  
Medical Society of Virginia

**HOD ACTION: Council on Medical Education Report 7 adopted as amended in lieu of Resolution 309 and the remainder of the report filed.**

REPORT 7 OF THE COUNCIL ON MEDICAL EDUCATION (A-14)  
Physician Workforce Shortage: Approaches to GME Financing  
(Resolution 914-I-13)  
(Reference Committee C)

EXECUTIVE SUMMARY

It is widely accepted that the United States is confronting a physician workforce shortage. Well before the enactment of the Patient Protection and Affordable Care Act (ACA), which is projected to provide previously unavailable health insurance to over 30 million people in the next several years—with an expected increase in healthcare demand—workforce researchers were projecting a physician shortage due to increasing demand from an aging population, current physicians aging into retirement, and other demographic shifts and changes within the healthcare setting. To that end, the number of allopathic and osteopathic medical schools has increased in recent years, and many existing schools have increased their class sizes. Current projections made by medical schools will match in 2017-2018 the targeted goal of a 30% increase in enrollment compared to 2002. However, there has not been a similar increase in graduate medical education (GME) positions, principally because the number of GME positions funded by Medicare has been capped at 1996 levels by the Balanced Budget Act of 1997. Although GME institutions have added positions to their training programs, most have been in subspecialty areas, as hospitals are limited in their ability to increase support for entry-level positions available to medical school graduates without prior GME. As a result, in recent years there has been a growing inability for medical school graduates to enter the specialty training programs of their choice. This situation is predicted to only worsen as increases to GME funding by Medicare, the primary funder of GME, are considered unlikely, and in fact some have called for a reduction in Medicare's support of GME.

This report reviews recent Congressional action to address the problem and what has occurred through the ACA in terms of expanding GME, and provides a synopsis of what 17 states are doing in order to increase their physician workforce or influence the specialty and location of physicians. Observations are included from research on state-level GME efforts that can inform states that are considering broadening their role in influencing GME locally. Barriers to GME expansion as well as proposed innovative training models are discussed. The AMA recommends that educators, accrediting agencies, funders and state policymakers consider innovations and flexibility in physician training to increase the physician workforce and reduce specialty shortages and maldistribution.

**HOD ACTION: Council on Medical Education Report 7 adopted as amended in lieu of Resolution 309 and the remainder of the report filed.**

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 7-A-14

Subject: Physician Workforce Shortage: Approaches to GME Financing  
(Resolution 914-I-13)

Presented by: Jeffrey P. Gold, MD, Chair

Referred to: Reference Committee C  
(Kesavan Kutty, MD, Chair)

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1 Referred Resolution 914-I-13, “Change Rural and Off Site Rural Training Track Requirements in  
2 order to Preserve and Encourage Interest in Rural Residency Programs,” introduced by the  
3 Mississippi Delegation, asked our AMA to:

- 4
- 5 1. Work with the Centers for Medicare & Medicaid Services to allow for up to one month in  
6 the second post graduate year and one month in the third post graduate year of an  
7 ABMS/AOA approved Family Medicine, General Internal Medicine or General Pediatric  
8 residency to occur in the office of a primary care physician who is listed and meets the  
9 qualifications for adjunct faculty of the sponsoring institution; and
- 10 2. Work with the Accreditation Council of Graduate Medical Education Residency Review  
11 Committee for Family Medicine and other specialties to adjust GME program requirements  
12 so that the patient encounters during this experience may count toward the continuity  
13 requirements for the completion of a residency.

14

15 Policy H-200.954 (12), “U.S. Physician Shortage,” asks our AMA to continue to study the effect of  
16 ever increasing match participants and the stagnant growth of U.S. residency positions with a  
17 report back at the 2014 Annual Meeting.

18

19 Policy D-305.967 (13), “The Preservation, Stability and Expansion of Full Funding for Graduate  
20 Medical Education,” asks our AMA to work with the Association of American Medical Colleges  
21 and other key stakeholders to continue to examine alternative models of funding for graduate  
22 medical education, with a report back at the 2014 Annual Meeting.

23

24 **INTRODUCTION**

25

26 This report builds on information provided in a previous Council Report to the House of Delegates  
27 on this topic (Council on Medical Education Report 5-A-13) and addresses the resolutions and  
28 policies above by providing information on:

- 29
- 30 1. The current state of the physician workforce;
- 31 2. Congressional actions and what the Patient Protection and Affordable Care Act (ACA)  
32 (P.L. 111-148) has accomplished;
- 33 3. Funding models for graduate medical education (GME) at the state level;
- 34 4. Current AMA policy; and
- 35 5. Recent AMA GME advocacy.

## 1 CURRENT STATE OF THE PHYSICIAN WORKFORCE

2  
3 Although there is not universal agreement, the understanding that the United States is confronting a  
4 physician workforce shortage has broad support. The expanded insurance coverage resulting from  
5 the ACA is estimated to provide health insurance for 34 million more people by 2016 (relative to  
6 2013), with an additional 3 million by 2023.<sup>1</sup> Assuming similar use and delivery of care patterns  
7 for these newly insured individuals, demand by the adult population for primary care physicians,  
8 including geriatricians, is estimated to grow 14% by 2025. Specialty care demand may increase  
9 from 16% for some services, up to 31% for others.<sup>2</sup> Even before the ACA was in place, various  
10 workforce research reports projected physician workforce shortages ranging from 35,000 to  
11 49,000.<sup>3,4</sup> As a result, the Association of American Medical Colleges (AAMC) in 2006  
12 recommended increasing medical school class sizes by 30% over 2002 levels.<sup>5</sup> Given the increased  
13 demands expected by the newly insured, the AAMC now projects a shortage of 45,000 primary  
14 care physicians and 46,000 specialty physicians by 2020.<sup>5</sup> The latest modeling by the National  
15 Center for Health Workforce Analysis projects a shortage of approximately 20,400 full-time  
16 equivalent primary care physicians by 2020.<sup>6</sup>

17  
18 Current enrollment projections made by medical schools will match in 2017-2018 the targeted goal  
19 of a 30% increase. First year enrollment in Liaison Committee on Medical Education (LCME)-  
20 accredited medical schools is now projected to be 21,434 in 2017-2018. First year enrollment in  
21 osteopathic medical schools is expected to reach 6,675 the same year.<sup>7</sup> The expansion in medical  
22 schools is not only in class size, but also includes some new schools in locations that did not  
23 previously have a medical school, such as in areas in several Southern states.<sup>7</sup> Existing schools that  
24 have expanded enrollments to a greater degree tend to have higher percentages of graduates who go  
25 on to practice in primary care specialties, and in rural or underserved areas.<sup>8</sup>

26  
27 Also continuing to contribute to the primary care workforce, and practice in underserved areas and  
28 treat low-income patients, are international medical graduates (IMGs)—in particular, non-U.S.  
29 citizen IMGs. Altogether, IMGs make up approximately 25% of the U.S. physician workforce.<sup>9,10</sup>

### 30 *Stagnant Growth of U.S. Residency Positions*

31  
32  
33 Although the United States is now educating more physicians in order to alleviate forecasted  
34 shortages, the lack of a concomitant increase in GME positions jeopardizes the nation's ability to  
35 increase the active physician workforce. The principal cause of this lack of growth is the Balanced  
36 Budget Act of 1997, which capped the number of GME positions funded by Medicare (the primary  
37 funding source for GME) at 1996 levels.

38  
39 Training institutions, in general, decide for themselves the number of physicians they can train, and  
40 the number of trainees overall has increased despite the cap, but principally in subspecialty areas.<sup>11</sup>  
41 Hospitals are able to create funding for these advanced positions, but are more limited in their  
42 ability to increase support for entry-level positions available to medical school graduates without  
43 prior GME. In fact, from 1998 to 2012, the number of first-year residents in GME programs  
44 accredited by the Accreditation Council for Graduate Medical Education (ACGME) has grown  
45 5.8%, an annual rate of only .4%. In comparison, growth in the number of fellows in subspecialty  
46 programs has been 71.2%, an annual growth rate of 4.7%.<sup>12,13</sup> The result has been a growing  
47 inability for medical school graduates to enter the specialty training programs of their choice. At  
48 the conclusion of the 2013 Match, run by the National Resident Matching Program (NRMP), which  
49 matches eligible applicants into ACGME-accredited training programs, 528 U.S. allopathic  
50 graduating seniors did not have a residency position,<sup>14</sup> approximately double the number of those  
51 who did not obtain a residency position in the 2012 Match. Data for the 2014 Match were not

1 available when this report was drafted, so it is unknown how many students ultimately were left  
2 without positions. Nonetheless, all indications point to a further tightening of residency positions in  
3 the coming years and an increase in the number of otherwise qualified medical school graduates  
4 who are not able to enter and complete a residency, which is a required component for medical  
5 practice in the United States.

6  
7 Total federal funding in 2012 for GME was \$11.1 billion,<sup>15</sup> including contributions from Medicare,  
8 Medicaid, Department of Defense, and Department of Veterans Affairs. Despite continuing  
9 advocacy by the AMA, AAMC, and other key stakeholders to increase GME funding, the current  
10 economic and political climate reflects a reluctance to increase GME funding as well as the  
11 possibility of reduced funding. The Medicare Payment Advisory Commission has recommended  
12 reducing indirect medical education payments to fund a new performance-based GME program.<sup>16</sup>  
13 The President's FY 2015 budget suggests ways to redistribute payments for medical education that  
14 may affect GME in academic medical centers, by reducing indirect payments by \$14.6 billion over  
15 ten years and then reinvesting these savings to train new health care providers in areas such as  
16 primary care and other high-need specialties. To encourage and enhance training of primary care  
17 practitioners and other physicians in high-need specialties, the budget proposes \$5.23 billion over  
18 10 years to support 13,000 new resident slots through a new competitive GME program that  
19 incentivizes high-quality physician training. This would replace current Teaching Health Center  
20 funding and Children's Hospital GME funding. In 2015, this new program would include \$100  
21 million in mandatory funding to support pediatric training in children's hospitals. In addition, the  
22 budget also calls for investments of more than \$3.9 billion over the next six years in the National  
23 Health Service Corps to place 15,000 health care providers in underserved areas.<sup>17</sup> Other  
24 organizations of note, including the Josiah Macy Jr. Foundation, and the Council of Graduate  
25 Medical Education, have called for more efficient methods of training physicians, as well as an  
26 examination of how resources are distributed to best produce the physicians the public needs.<sup>18</sup>

## 27 28 CONGRESSIONAL ACTIONS AND WHAT THE ACA HAS ACCOMPLISHED

29  
30 To counteract the impact of the Balanced Budget Act's cap on residency positions, bills have been  
31 introduced that would increase the number of GME slots funded by Medicare by 15%, or roughly  
32 15,000 (S. 577, H.R. 1180, H.R. 1201). In addition, H.R.297, the "Children's Hospital GME  
33 Support Reauthorization Act of 2013," would reauthorize federal funding to support GME for free-  
34 standing children's hospitals. The likelihood of these bills being seriously considered, however, is  
35 remote, given the current fiscal and political environment.

36  
37 Nonetheless, federal support for some expansion in GME has come through various programs that  
38 are part of the ACA. In 2010, for example, the Health Resources and Services Administration  
39 (HRSA) awarded \$167.3 million to fund 82 primary care residency training programs for five  
40 years, as part of the Primary Care Residency Expansion Program (PCRE) for 2010-2014. The  
41 program provides \$80,000 per resident, per year, for three years. Most of the awardees have as  
42 missions a goal to increase diversity and/or address cultural competency, and work in partnership  
43 with Federally Qualified Health Centers, community hospitals, and other community health  
44 settings. It is estimated that 889 new physicians will be trained through this program, with an  
45 average expansion size of two residency positions per year.<sup>19</sup>

46  
47 Through Section 5508 of the ACA, the Teaching Health Center Graduate Medical Education  
48 program (THC GME), \$230 million is available to fund increases in primary care residency  
49 training and general or pediatric dentistry training in community-based settings. This program  
50 provides payments to support both direct and indirect expenses for newly established THCs or for

1 expansion in existing THCs. As of July 2013, 21 THCs were awarded grants, training more than  
2 300 residents in 2013-2014, twice as many as in the previous academic year.<sup>20</sup>

3  
4 Through Section 5503 of the ACA, unfilled GME positions were converted to primary care  
5 positions in 2011. Certain geographic areas and types of hospitals were given preference for  
6 redistributed positions, e.g., states with low resident physician-to-population ratio and hospitals  
7 with rural training programs. Altogether, 726 direct graduate medical education (DGME)-funded  
8 and 628 indirect medical education (IME)-funded resident slots were redistributed. It is estimated  
9 that this program will increase the number of residents trained per year by 200.<sup>19</sup>

10  
11 Section 5506 of the ACA calls for the preservation of GME positions when a hospital closes; prior  
12 to the ACA, these positions would be lost. Now these positions can be allocated to existing  
13 hospitals, generally in the same geographic area.

14  
15 Section 5207 of the ACA reauthorizes the National Health Service Corps (NHSC) and provides  
16 increased support with new dedicated funding for 2011 through 2015. The NHSC does not  
17 necessarily increase the physician workforce per se, but may affect the physician supply in that it  
18 provides loan repayment for students and physicians who commit to primary care practice in  
19 underserved areas.<sup>19</sup>

20  
21 Although the opportunities provided through the ACA are welcome, many of the awards are time-  
22 limited through fiscal year 2015 (with resources scarce within some states to continue the funding),  
23 and these efforts do not ultimately increase the number of physicians trained to adequately meet  
24 anticipated workforce needs.

## 25 26 FUNDING MODELS FOR GME AT THE STATE LEVEL

27  
28 Because of the uncertain or diminished likelihood of significantly increased federal support for  
29 GME funding, and frustration with the lack of influence over the specialty choices and locale of  
30 physicians practicing in their states, several states have proposed and/or enacted programs that aim  
31 to expand residency positions via alternative GME funding, and/or encourage physicians to  
32 practice in the state after the required GME is completed. Below are key examples of such efforts.

### 33 34 *Expansion of Residency Positions through Alternative Financing*

35  
36 California: The state legislature introduced AB 1176, "Primary Care Access: Residency Programs,"  
37 that proposed a \$5 per covered life fee for health insurers to fund GME. Besides creating a body to  
38 distribute GME funding to new and existing programs, eligibility for funds is based on a program's  
39 location in an underserved area; record of placing graduates in underserved areas; training in  
40 primary care; or undersupplied specialties in the local community. The bill is eligible to be taken  
41 up in 2014.

42  
43 Florida: State and private funding options have been pursued, and various models have been used  
44 for GME funding. In 2013, the state legislature used \$20.6 million in state funds, coupled with \$52  
45 million in existing funds, to provide \$80 million in supplemental funding for a Statewide Medicaid  
46 Residency Program (Senate Bill [S.B.] 1520). For this program, GME funds related to Medicaid  
47 are removed from regular hospital reimbursement payments and will instead be subject to a  
48 formula-based distribution. Each hospital participating in the program will receive an annual  
49 allocation determined by a calculation of the hospital's percentage of total residents statewide and  
50 the hospital's percentage of total Medicaid inpatient reimbursement among participating hospitals.  
51 By definition, this program can only increase residency positions/programs in hospitals with

1 existing programs. In 2010, S.B. 1256, "Physician Workforce," which passed committees in the  
2 State Senate, was to have funded the direct costs of innovative GME programs, among other  
3 physician workforce goals; the bill did not become law.

4  
5 Georgia: Beginning in FY 2013, dollar-for-dollar funds are available from the state for hospitals to  
6 start residency programs. The goals of this funding stream include creating 400 new positions in  
7 hospitals that previously had no programs, ensuring some concentration in primary care specialties  
8 and general surgery, and developing residencies in geographically underserved parts of the state.  
9 Currently four hospitals are developing programs, with the potential of creating upwards of 267  
10 positions. Funding is only for the process of creating a program, thus covering accreditation costs,  
11 hiring staff, purchasing new equipment and so forth. Once a hospital has residents enrolled and is  
12 receiving Medicare funds, the state program ceases to support the hospital.

13  
14 Hawaii: The state legislature and governor approved a \$1.8 million appropriation for the Primary  
15 Care Training Program at Hilo Medical Center, which will support several disciplines, including  
16 four new family medicine residents a year for three years.

17  
18 Idaho: The state legislature recently funded a new family medicine program. In addition, the  
19 Family Medicine Residency of Idaho received from the Blue Cross Foundation of Idaho \$100,000  
20 per year to support rural rotations for residents.

21  
22 Maryland: The state boasts an all-payer system to fund GME, the only one in the nation, which is  
23 managed through the Health Service Cost Review Commission (HSCRC). However, in recent  
24 years no additional funding has been requested explicitly for new programs or positions. The  
25 HSCRC has no role in influencing the number or specialty of residents in training.

26  
27 Minnesota: Clinical training sites consisting of a variety of health professions are supported  
28 through the Medical Education and Research Costs program; these grants are provided through  
29 state and federal Medical Assistance funds and cigarette tax proceeds. The FY 2014-15 base budget  
30 is \$44.3 million. New in FY 2013 was a \$1 million per year grant program for family medicine  
31 residency programs outside the seven-county metropolitan area. To be eligible, programs must  
32 demonstrate that at least 25% of graduates practice in Minnesota communities outside the  
33 metropolitan area for the most recent three years.

34  
35 Montana: In 2013, the legislature added \$200,000 to the state's appropriation for GME, and also  
36 approved an additional \$240,000 to support rural rotations for residents.

37  
38 North Carolina: The Blue Cross Blue Shield of North Carolina Foundation is providing partial  
39 funding to establish the University of North Carolina Family Medicine's Underserved Residency  
40 Track, which will train two residents per year for three years in underserved communities.

41  
42 North Dakota: The Health Care Workforce Initiative, funded by state government, will allow the  
43 University of North Dakota School of Medicine and Health Sciences to expand with the  
44 expectation that by the 2017-2018 academic year, there will be 64 additional medical students (16  
45 per year), 90 health sciences students (30 per year), and 51 residents (post-MD degree trainees,  
46 with 17 per year added). This initiative is expected to retain more of the graduates for practice in  
47 North Dakota.

48  
49 Oklahoma: In 2012, the state legislature allocated \$3 million to establish new primary care  
50 residency programs in underserved areas, administered by the Oklahoma State University College



1 of Osteopathic Medicine or the University of Oklahoma College of Medicine, with the expectation  
2 that the programs become funded by Medicare.

3  
4 Tennessee: There is discussion of redirecting the professional privilege tax that licensed physicians  
5 pay towards expansion of GME funding. Replacement dollars need to be identified or a reduction  
6 in expenses would be required, as this tax adds approximately \$8 million to the general fund.

7  
8 Texas: House Bill (H.B.) 2908, which was adopted in 2011, directed the Texas Higher Education  
9 Coordinating Board to conduct assessments of the state's GME system to accommodate the  
10 training needs of the state's medical school graduates. During 2013, the legislature appropriated  
11 \$16.3 million for grants to develop new GME programs, expand existing programs, and help fill  
12 existing unfilled GME positions. Funding of \$7.4 million goes to up to 25 first-year  
13 unfilled/unfunded GME slots and up to 63 new first-year positions at existing or new programs, at  
14 \$65,000 per year per resident, for one year. In addition, \$5 million goes to encourage development  
15 of new GME positions through community collaboration and innovative funding, for new positions  
16 created on or after January 1, 2014, or positions unfilled on January 1, 2013. Additional funding  
17 depends upon appropriation. The balance goes to planning grants and primary care innovation  
18 programs to encourage more students to enter primary care. Concerns revolve around funding  
19 beyond the first year.

20  
21 Wisconsin: New funding for several new GME initiatives has recently been approved, including  
22 \$1.7 million to increase the Medical College of Wisconsin's (MCW) family medicine programs by  
23 12 new positions, primarily in underserved areas of Milwaukee. The state has also made a start-up  
24 investment for MCW's planned new programs in northeastern and central Wisconsin. In addition,  
25 the Wisconsin Department of Health Services will be supporting 10 new residency slots in existing  
26 programs, targeting specialties in need (family medicine, general internal medicine, general  
27 surgery, pediatrics, and psychiatry) and in rural locations. Programs can apply for expansion of up  
28 to three positions (three in one year, or one in each of three years). Programs in bordering states are  
29 eligible if they have a substantial presence in Wisconsin (e.g., rotations in the state, graduates who  
30 practice in Wisconsin). The state is seeking matching Medicaid funds, which would allow for  
31 doubling the number of new positions. Finally, the state will assist rural hospitals or consortia of  
32 rural hospitals to develop new residency programs, with up to \$1.75 million available for three  
33 years, limited to the same specialties as above.

#### 34 35 *Retention of Physicians*

36  
37 At least 30 states use, or plan to use, some kind of loan forgiveness/repayment program to  
38 encourage physicians to practice in primary care and or/underserved area. There generally are  
39 stipulations as to how long the service must be, and maximum dollar amounts allowed.

40  
41 California: S.B. 21, signed into law in 2013, requests that the newly accredited University of  
42 California Riverside School of Medicine identify eligible residents and assist them with applying to  
43 physician retention programs, such as loan repayment programs, that require service to an  
44 underserved or rural area of the state in exchange for debt assistance.

45  
46 Iowa: The state's Rural Physician Loan Repayment program is funded as a public/private  
47 partnership. Specialties are either primary care or otherwise approved; physicians are Iowa-trained  
48 and must commit to serve for five years in a community with fewer than 26,000 residents that is  
49 more than 20 miles from a large city in exchange for up to \$50,000 per year for four years of loan  
50 repayment. Private donations are added to the nearly \$2 million state appropriation for the fund.

1 The expectation is that eventually the fund will be able to forgive student debt for 20 physicians  
2 each year—10 from the University of Iowa and 10 from Des Moines University.

3  
4 New York: Loan repayment program of \$30,000 per year for a two-year commitment to serve in a  
5 NY health professions shortage area (HPSA).

6  
7 North Dakota: Tuition forgiveness for medical students at the University of North Dakota School  
8 of Medicine and Health Sciences who commit to practicing primary care in a rural area in the state.

9  
10 Ohio: The state’s Council of Medical School Deans has proposed a GME funding program that  
11 would accept and fund residents based on individual characteristics and planned intentions to  
12 practice in primary care, rural areas and/or underserved areas. The intent is to use Medicaid funds  
13 to create a workforce that best meets the state’s needs and reduce exporting physicians to other  
14 states.

15  
16 Tennessee: Loan repayment program of \$60,000 per year for a two-year commitment, and up to  
17 \$40,000 per year after that, in exchange for service in a HPSA, federally qualified health center, or  
18 rural health center.

19  
20 Texas: Loan repayment funding is currently part of an appropriations bill. Also, the state monitors  
21 NRMP Match results to identify the number of students who leave Texas for training in specialties  
22 that do not have enough positions in-state.

23  
24 *Lessons Learned from State GME Stakeholders*

25  
26 The Cecil G. Sheps Center of the University of North Carolina recently published an analysis of in-  
27 depth GME stakeholder interviews from a nationally representative sample of states.<sup>21</sup> Key  
28 informants included medical educators and government employees with knowledge of state-level  
29 GME policy, as well as medical association health policy specialists. Several relevant lessons  
30 learned include: 1) states can learn from one another about data collection and GME data analysis  
31 to inform policy; 2) although Medicaid is a policy lever states can use to modify health care  
32 delivery, with few exceptions states have not been able to effectively use Medicaid GME funding  
33 to target GME expansion; 3) although expansion through the ACA has been important and  
34 innovative in expanding GME training in needed specialties and geographic areas, with a measure  
35 of accountability not found elsewhere in federal GME funding, the lack of sustainability in the  
36 funds has made programs vulnerable to closure and recruitment of residents difficult; 4) if there are  
37 new state funding streams for GME (either through instituting an all-payer system, state  
38 appropriations, or third party payers mandated by legislation), funding must be sustainable to  
39 ensure long-term impact; 5) metrics for in-state retention or other accountability measures are  
40 infrequent, and expansion efforts have often been in response to teaching hospitals’ own service  
41 needs rather than population health needs; and 6) two more effective strategies for states may be to  
42 invest in core specialties in programs in underserved areas, and to use non-GME funding such as  
43 loan repayment programs.

44  
45 The report concluded with five recommendations that can inform states that are considering  
46 broadening their role in influencing GME locally:

47  
48 Recommendation 1: States should develop ongoing physician workforce data collection  
49 systems that allow policy makers to continuously identify the changing workforce needs of the  
50 state.

1 Recommendation 2: States should create a GME advisory entity that promotes discussion,  
2 coordination and education about GME.

3  
4 Recommendation 3: All payer, third-party payer, Medicaid and state appropriations for GME  
5 need to be carefully considered and designed to be responsive to the state's population health  
6 needs.

7  
8 Recommendation 4: New GME funding should be tied to performance metrics and require  
9 monitoring about how funds are spent.

10  
11 Recommendation 5: State policy makers should coordinate efforts that touch on the physician's  
12 entire career from medical school admissions through GME and into practice.<sup>21</sup>

### 13 14 AMA POLICY

15  
16 AMA policy supports maintaining adequate and stable Medicare and Medicaid GME funding  
17 levels and advocates for contributions by all payers of health care to fund GME (e.g., federal  
18 government, states, and private payers). In addition, the AMA supports exploring additional  
19 sources of funding, and in particular new funding to support increases in training positions,  
20 preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties.  
21 For example, Policy H-305.929 (4), "Proposed Revisions to AMA Policy on the Financing of  
22 Medical Education Programs," states that diversified sources of funding should be available to  
23 support medical schools' multiple missions, including education, research, and clinical service.  
24 Reliance on any particular revenue source should not jeopardize the balance among a medical  
25 school's missions. Policy D-305-967 (11), "The Preservation, Stability, and Expansion of Full  
26 Funding for Graduate Medical Education," states that the AMA recognizes that funding for and  
27 distribution of positions for GME are in crisis in the United States and that meaningful and  
28 comprehensive reform is urgently needed, and directs the AMA to immediately work with  
29 Congress to expand medical residencies in a balanced fashion based on expected specialty needs  
30 throughout our nation to produce a geographically distributed and appropriately sized physician  
31 workforce, and to make increasing support and funding for GME programs and residencies a top  
32 priority of the AMA in its national political agenda. Policy D-310.953, "Exploring the Feasibility  
33 of Clinic-based Residency Programs," advocates that key stakeholders, such as the Accreditation  
34 Council for Graduate Medical Education, explore the feasibility of extending residency programs  
35 through a pilot study placing medical graduates in integrated physician-led practices in order to  
36 expand training positions and increase the number of physicians providing healthcare access; and  
37 encourages that pilot studies of clinic-based residency program expansion be funded by private  
38 sources. (Other relevant AMA policy is in the Appendix.)

### 39 40 RECENT AMA ADVOCACY REGARDING GME

41  
42 In addition to supporting H.R. 297, the "Children's Hospital GME Support Reauthorization Act of  
43 2013," and S.577 and H.R. 1180, the "Resident Physician Shortage Reduction Act" in 2013, the  
44 AMA launched in August 2013 a national "Save GME Action Week" to raise awareness about the  
45 cap on funding for residency training programs. Students from over 50 medical schools across 20  
46 states met with their representatives and senators to advocate for GME funding and solutions to  
47 pending physician shortages.

48  
49 The AMA also recently expanded its Save GME website (SaveGME.org) and began issuing bands  
50 that can be worn on stethoscopes as a symbol of our GME campaign. These advocacy efforts have

1 generated significant support, resulting in over 26,000 letters urging lawmakers to protect GME  
2 funding.

3  
4 In November 2013, during the AMA Interim Meeting, the Council on Medical Education convened  
5 a meeting of leaders from GME programs, state medical societies, and national medical  
6 organizations to discuss concerns, initiatives and potential collaborations that may be needed to  
7 respond to the GME crisis in terms of how it may impact medical education and the physician  
8 workforce in the future.

## 9 10 DISCUSSION

### 11 12 *Barriers to Expansion*

13  
14 Limited GME funding may not be the only barrier to an expansion in the number of GME  
15 positions. Although well-established GME institutions have the infrastructure in place for  
16 expansion, most are likely at capacity or, if considering expansion, would choose hospital-intensive  
17 specialties. There appears to be limited consideration for physician workforce needs, either  
18 nationally or locally, among many academic health centers.<sup>22,23</sup> Obvious candidates for substantial  
19 expansion, so-called GME “naïve” or “virgin” hospitals, such as community hospitals, and in  
20 particular rural hospitals, may not be able to increase capacity at the desired rate, or lack the patient  
21 base needed to meet accreditation standards. Though these GME-naïve hospitals may not be ideal  
22 candidates for stand-alone residency programs, many of them may serve a role as additional sites to  
23 increase the capacity of existing GME programs with established infrastructure and oversight.  
24 Funding rural training networks, flexibility and innovation within ACGME standards, altering  
25 Medicare GME reimbursement to increase the viability of rural training, and possibly reducing the  
26 time needed to complete training in core specialties are ideas that have been proposed to ease entry  
27 into GME by new institutions.<sup>24,25</sup>

28  
29 Barriers within states to an expansion of GME have been identified as including:

- 30
- 31 • A lack of reliable data on GME and its state-wide implications on physician workforce,
  - 32 • Lack of understanding by state policy makers of how Medicaid can be used to supplement  
33 Medicare GME funding,
  - 34 • The effect on state appropriations of temporal swings in state politics,
  - 35 • Lack of state-level GME decision-making authorities/entities, and
  - 36 • The attractiveness to politicians and their constituents of developing a new medical school  
37 versus adding residency training programs.<sup>21</sup>
- 38

### 39 40 *Changes Within the Health Care Delivery System*

41 Reforms within the health care delivery system, if enacted comprehensively, could reduce the  
42 physician shortage, and therefore mitigate the need for GME expansion. Demonstrations of  
43 accountable care organizations (ACOs) are still ongoing, but theoretically the emphasis on  
44 preventive care and team management of chronic conditions provide a more efficient model of  
45 work for physicians.<sup>2</sup> ACOs and patient-centered medical homes could allow for more patients  
46 served per physician resulting from team productivity and coordination; alternatively, the greater  
47 levels of physician coordination and higher levels of patient education desired may not produce this  
48 efficiency.<sup>26</sup> There may be limitations to the acceptance of ACOs. Development of ACOs in rural  
49 areas may be challenging,<sup>27</sup> and so far nine of 32 ACOs have left the pioneer program.<sup>28</sup>

1 Some have suggested that payment reform, training non-clinicians in new responsibilities,  
2 personnel efficiency resulting from the inevitability of smaller practices joining networks or  
3 systems, innovations in technology, and promoting an innovation culture might help to address the  
4 primary care demand-physician capacity mismatch without relying solely on expansion of GME.<sup>29</sup>  
5 As noted in the Council on Medical Education and Council on Medical Service Joint Report 1-I-12  
6 (Joint Report), “The Structure and Function of Interprofessional Health Care Teams,” improved  
7 teamwork holds the promise of alleviating patient access to health care challenges caused by the  
8 shortage of primary care physicians. The Joint Report defined “team-based health care” as the  
9 provision of health care services by a physician-led team of at least two health care professionals  
10 who work collaboratively with each other, the patient, and the family to accomplish shared goals  
11 within and across settings to achieve coordinated, high-quality, patient-centered care (Policy H-  
12 160.912, “The Structure and Function of Interprofessional Health Care Teams”). HRSA suggests  
13 that a full integration of nurse practitioners (NPs) and physician assistants (PAs) into the health  
14 care system could mitigate the projected primary care physician shortage;<sup>6</sup> adding NPs and PAs to  
15 physician-led medical teams may improve efficiency. Council on Medical Service Report 6-A-14,  
16 also being considered at this meeting, calls on the AMA to study and report back on the definition  
17 of leadership in physician-led medical teams, and to propose acceptable models that value the  
18 expertise of the physician and models that can be used by medical teams that address specific  
19 issues such as patient safety, the nature of physician authority within the teams, and the ethical and  
20 legal issues of the team model.

### 21 22 *Flexibility and Innovation*

23  
24 The increased scrutiny in previously unquestioned public funding of GME and the current fiscal  
25 and political climate makes a surge in new Medicare funding dedicated to GME expansion  
26 doubtful and the possibility of significant cuts an ongoing concern.<sup>16</sup> Pairing a growing interest in  
27 social accountability within the GME community<sup>30</sup> with innovations in medical education  
28 (undergraduate and graduate), and increased physician workforce concerns among state health  
29 policymakers, could produce models of GME that would create physicians in needed specialties  
30 and with affinities towards rural and team-based care. The ACGME’s Milestones Project and the  
31 Next Accreditation System<sup>31</sup> are considered a first step in accountability and competency-based  
32 education in GME. If Medicare or state policymakers were to incentivize the collection and  
33 utilization of outcomes data, then a future funding system that rewarded programs based on desired  
34 outcomes could develop.<sup>32</sup> An educational system that is performance- rather than time-based  
35 could shorten the length of training, and thus decrease the lengthy educational pipeline.<sup>30,33</sup> A  
36 recent proposal that rewards innovation, quality, and accountability through competitive funding  
37 merits attention. This model of funding could be incremental, and could also be administered  
38 locally rather than federally (and indeed resembles some proposed models of state-level GME  
39 funding). Training programs meeting social needs (e.g., primary and/or rural care, community-  
40 based training, team-based care) while maintaining high quality standards would be rewarded with  
41 greater funding, and thus could expand; programs that were uncompetitive would lose funded  
42 positions.<sup>18</sup>

### 43 44 SUMMARY AND RECOMMENDATIONS

45  
46 The Council on Medical Education realizes that the U.S. health care system is at a turning point;  
47 models of health care delivery and funding are changing much more rapidly than our current  
48 system of educating and training physicians. The projected result is a patient population without  
49 adequate access to physicians. Beyond advocating with the AAMC and other stakeholders that  
50 expansion of the GME is necessary, the AMA should also be a proponent of innovations in training  
51 that will enable future physicians to best serve the health care needs of the public.

1 The Council on Medical Education recommends that the following recommendations be adopted in  
2 lieu of Resolution 914-I-13 and that the remainder of the report be filed.

- 3  
4 1. That our American Medical Association continue to strongly advocate that Congress fund  
5 additional graduate medical education (GME) positions for the most critical workforce  
6 needs, especially considering the current and worsening maldistribution of physicians.  
7 (Directive to Take Action)  
8
- 9 2. That our AMA advocate that the Centers for Medicare & Medicaid Services allow for rural  
10 and other underserved rotations in Accreditation Council for Graduate Medical Education  
11 (ACGME)-accredited residency programs, in disciplines of particular local/regional need,  
12 to occur in the offices of physicians who meet the qualifications for adjunct faculty of the  
13 residency program's sponsoring institution. (Directive to Take Action)  
14
- 15 3. That our AMA encourage the ACGME to reduce barriers to rural and other underserved  
16 community experiences for graduate medical education programs that choose to provide  
17 such training, by adjusting as needed its program requirements, such as continuity  
18 requirements or limitations on time spent away from the primary residency site. (Directive  
19 to Take Action)  
20
- 21 4. That our AMA encourage the ACGME and the American Osteopathic Association (AOA)  
22 to continue to develop and disseminate innovative methods of training physicians  
23 efficiently that foster the skills and inclinations to practice in a health care system that  
24 rewards team-based care and social accountability. (Directive to Take Action)  
25
- 26 5. That our AMA work with interested state and national medical specialty societies and other  
27 appropriate stakeholders to share and support legislation to increase GME funding,  
28 enabling a state to accomplish one or more of the following: (1) train more physicians to  
29 meet state and regional workforce needs; (2) train physicians who will practice in  
30 physician shortage/underserved areas; or (3) train physicians in undersupplied specialties  
31 and subspecialties in the state/region. (Directive to Take Action)  
32
- 33 6. That our AMA support the ongoing efforts by states to identify and address changing  
34 physician workforce needs within the GME landscape and continue to broadly advocate for  
35 innovative pilot programs that will increase the number of positions and create enhanced  
36 accountability of GME programs for quality outcomes. (Directive to Take Action)  
37
- 38 7. That our AMA continue to work with stakeholders such as Association of American  
39 Medical Colleges, ACGME, AOA, American Academy of Family Physicians, and  
40 American College of Physicians, and other specialty organizations to analyze the changing  
41 landscape of future physician workforce needs as well as the number and variety of GME  
42 positions necessary to provide that workforce. (Directive to Take Action)  
43
- 44 8. That our AMA rescind Policies H-200.954 (12), "U.S. Physician Shortage," and D-305.967  
45 (13), "The Preservation, Stability and Expansion of Full Funding for Graduate Medical  
46 Education," since these have been accomplished through this report. (Rescind HOD  
47 Policy)

Fiscal Note: \$1,000.

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APPENDIX

*AMA Policies on GME Financing and Medical Workforce*

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

It is AMA policy that: (1) Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public. (2) Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved. (3) Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding. (4) Diversified sources of funding should be available to support medical schools’ multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school’s missions. (5) All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding. (6) Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage. (7) Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training. (8) Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs. (9) New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties. (CME Rep. 7, A-05; Reaffirmation I-06; Reaffirmed: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmed: CME Rep. 15, A-10; Reaffirmation A-11; Reaffirmation A-13; Reaffirmed: CME Rep. 5, A-13)

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

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others). 2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions. 3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997). 4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation. 5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty. 6. Our AMA will

oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.). 7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care. 8. Our AMA will vigorously advocate for the contribution by all payers for health care, (including the federal government, the states and private payers), to funding both the direct and indirect costs of GME. 9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality. 10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME. 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 work with the Association of American Medical Colleges and other key stakeholders to continue to examine alternative models of funding for graduate medical education, with a report back at the 2014 Annual Meeting. (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)

*Workforce shortages and access to care*

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)

H-200.982 “Significant Problem of Access to Health Care in Rural and Urban Underserved Areas”

1. Our AMA encourages state legislatures and the Congress of the United States to recognize this significant problem and to develop rapidly incentives to make practice in rural and urban underserved areas more attractive to primary care physicians in order to provide access to necessary medical services in these areas. 2. Our AMA will encourage the Centers for Medicare & Medicaid Services, American Osteopathic Association, Accreditation Council for Graduate Medical Education, American Board of Medical Specialties and the Association of American Medical Colleges to foster the development of innovative training programs for medical students, residents and fellows in rural and underserved areas so that the number of physicians increases in these underserved areas, which would facilitate the elimination of geographic, racial, and other health care disparities. (Sub. Res. 35, I-90; Reaffirmed: BOT Rep. GG, I-92; Reaffirmation A-01; Modified: CME Rep. 2, I-03; Appended: Res. 320, A-10)

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

In light of the data available from the current literature as well as ongoing studies being conducted by staff, the AMA recommends that: (1) 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. (2) 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. (3) Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians. (4) 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. (5) Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas. (6) 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. (7) Our AMA support full funding of the new federal National Health Service Corps loan repayment program. (8) 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. (9) Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians. (10) Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages. (11) Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible. (12) Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners. (CME Rep. C, I-90; Reaffirmation A-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmed: CME Rep. 1, I-08)

*Rural and off-site training requirements*

H-200.982 “Significant Problem of Access to Health Care in Rural and Urban Underserved Areas”

1. Our AMA encourages state legislatures and the Congress of the United States to recognize this significant problem and to develop rapidly incentives to make practice in rural and urban underserved areas more attractive to primary care physicians in order to provide access to necessary medical services in these areas. 2. Our AMA will encourage the Centers for Medicare & Medicaid Services, American Osteopathic Association, Accreditation Council for Graduate Medical Education, American Board of Medical Specialties and the Association of American Medical Colleges to foster the development of innovative training programs for medical students, residents and fellows in rural and underserved areas so that the number of physicians increases in these underserved areas, which would facilitate the elimination of geographic, racial, and other health care disparities. (Sub. Res. 35, I-90; Reaffirmed: BOT Rep. GG, I-92; Reaffirmation A-01; Modified: CME Rep. 2, I-03; Appended: Res. 320, A-10)

H-465.988 Educational Strategies for Meeting Rural Health Physician Shortage

In light of the data available from the current literature as well as ongoing studies being conducted by staff, the AMA recommends that: (1) 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. (2) 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. (3) Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians. (4) 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. (5) Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas. (6) 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. (7) Our AMA support full funding of the new federal National Health Service Corps loan repayment program. (8) 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. (9) Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians. (10) Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages. (11) Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible. (12) Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners. (CME Rep. C, I-90; Reaffirmation A-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmed: CME Rep. 1, I-08)

*Innovations in training*

D-295.934 “Encouragement of Interprofessional Education Among Health Care Professions Students”

1. Our AMA: (A) recognizes that interprofessional education and partnerships are a priority of the American medical education system; and (B) will explore the feasibility of the implementation of Liaison Committee on Medical Education and American Osteopathic Association accreditation standards requiring interprofessional training in medical schools. 2. Our AMA supports the concept

that medical education should prepare students for practice in physician-led interprofessional teams. 3. Our AMA will encourage health care organizations that engage in a collaborative care model to provide access to an appropriate mix of role models and learners. 4. Our AMA will encourage the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to facilitate the incorporation of physician-led interprofessional education into the educational programs for medical students and residents in ways that support high quality medical education and patient care. 5. Our AMA will encourage the development of skills for interprofessional education that are applicable to and appropriate for each group of learners. (Res. 308, A-08; Appended: CME Rep. 1, I-12)

D-200.979 “Barriers to Primary Care as a Medical School Choice”

1. In collaboration with relevant specialty societies, our AMA will take the following actions related to reimbursement for primary care physician services: a. Continue to advocate 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. b. Work to assure that private payers fully recognize the value of E&M services, incorporating the RUC recommended increases adopted for the most current Medicare RBRVS. 2. In collaboration with relevant specialty societies, our AMA will study the following related to new models of provision of primary care services (such as the medical home concept): a. the impact on primary care physician work-life balance and satisfaction, b. the growth/expansion of such models in the public and private sectors, c. the availability of expanded public- and private-sector funding at the national and local levels to support implementation of such models. d. the impact on primary care physician compensation. e. options that explore additional funding. The results of the study shall be reported no later than the 2010 Annual Meeting of the AMA House of Delegates. 3. Our AMA supports existing programs and advocate for the introduction of new programs in the public and private sectors that decrease the debt load of physicians who choose to practice in a primary care specialty. 4. Our AMA will continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. 5. Our AMA will collaborate with appropriate organizations to support the development of innovative models to recruit medical students interested in primary care, to train primary care physicians, and to enhance the image of primary care practice. 6. Our AMA will collaborate with appropriate organizations in urging medical schools to develop policies and to allocate appropriate resources to activities and programs that encourage students to select primary care specialties, including: a. admissions policies b. utilization of primary care physicians in the roles of teachers, mentors, and role models, and c. educational experiences in community-based primary care settings. 7. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) to develop an accreditation environment and novel pathways that promote innovations in training that use progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model. 8. Our AMA will advocate for public (federal and state) and private payers to develop enhanced funding and related incentives from all sources to provide graduate medical education for resident physicians and fellows 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 in order to enhance primary care as a career choice. 9. Our AMA will advocate for public (federal and state) and private payers to develop enhanced funding and related incentives from all sources to provide undergraduate medical education for students 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 in order to enhance primary care as a career choice. 10. 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. (CME Rep. 3, I-08; Appended: CME Rep. 8, A-10)