HOD ACTION: Council on Medical Education Report 1 adopted as amended and the remainder of the report filed.

REPORT 1 OF THE COUNCIL ON MEDICAL EDUCATION (I-15)
(Resolution 931-I-14, Resolution 312-A-15)
Sources of Funding for Graduate Medical Education
(Reference Committee K)

EXECUTIVE SUMMARY

Since the Balanced Budget Act of 1997, the number of Medicare-funded graduate medical education (GME) positions has been capped at 1996 levels, and there is little political will for increasing Medicare's contribution to GME. Despite the Medicare cap, the number of residents and fellows has increased since 1997, as new training programs have been created in hospitals that previously had no GME, and hospitals have been able to obtain non-Medicare funding. This growth has occurred disproportionately in subspecialty areas. A few states have been successful at expanding GME by: 1) developing GME programs in core specialty areas; 2) expanding Medicaid funding; 3) proposing new tax structures; and 4) developing partnerships with local foundations and insurance companies. State expansion has principally been in primary care, in rural and underserved areas.

The slow growth in federal funding of GME through Medicare, and the reluctance of most states to expand Medicaid GME funding, has led to an interest in the pursuit of other sources of funding. The expansion of existing residency programs or the creation of new ones through funding other than Medicare or through state contributions is a complex process. This report briefly presents examples of private and alternative funding for GME, both current and past; describes proposals for new models of funding; and presents an example of a program expansion that can serve as the groundwork for the development of model guidelines for program expansion.

Pharmaceutical industry and private foundation support of GME has principally supported subspecialty fellowships, funded supplemental educational material that may be otherwise inaccessible, or has been in the form of grants for research and community service. Pharmaceutical support has not been without criticism, and foundations are not a likely resource for ongoing, sustainable GME program expansion on a large scale. Proposals for national models of GME funding by all payers may involve a tax, either on the number of insured enrollees or on medical billings, and do not all have the goal of increasing the number of GME positions (but may have the goal of increasing primary care positions, or decreasing reliance on Medicare funding). The example of the expansion of one family medicine program in North Carolina demonstrates the complicated undertaking of developing relationships with at least three different foundations/philanthropic organizations, as well as amplifying the support by the sponsoring institution and the clinical site.

The expansion of GME positions or programs should not occur without protections for the safety of trainees or their patients. Enthusiasm for residency program creation or expansion in the face of workforce shortages and physician geographic maldistribution should not diminish the importance of ensuring a safe and productive learning and clinical environment for both residents and patients.

The AMA recommends further study of all-payer models of GME funding, and encourages the development of state, local community, insurance industry and foundation partnerships for creating successful models of program expansion.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-I-15

Subject: Sources of Funding for Graduate Medical Education (Resolution 931-I-14, Resolution 312-A-15)

Presented by: Darlyne Menscer, MD, Chair

Referred to: Reference Committee K (Hillary Johnson-Jahangir, MD, Chair)

Resolution 931-I-14, introduced by the Virginia, South Carolina, West Virginia and Kentucky Delegations and referred to the Board of Trustees, asked that our American Medical Association (AMA): 1) encourage and advocate for private and alternative sources of funding for graduate medical education (GME) educational opportunities; 2) support when appropriate and advocate for additional sources of funding for private payers to support both direct and indirect costs of graduate medical education and explore funding for additional residency slots; and 3) encourage state and specialty societies to seek private and alternative sources of funding for state-specific graduate medical educational opportunities.

Resolution 312-A-15, introduced by the International Medical Graduates Section and referred to the Board of Trustees, asked that our AMA facilitate a working group that includes the International Medical Graduates Section, Medical Student Section, Resident and Fellow Section, Section on Medical Schools, Council on Medical Education and other stakeholders, with the charge of creating model guidelines for expansion of existing residency programs, with funding support from non-federal donors.

Due to the complexity of the issues that these two items encompass, both were referred to the Council on Medical Education by the AMA Board of Trustees for a report back to the House of Delegates. Accordingly, this report: 1) briefly summarizes current funding for GME; 2) presents examples of private and alternative funding for GME, both current and past; 3) describes proposals developed for new models of funding; and 4) presents an example of a program expansion that can serve as the groundwork for the development of model guidelines for program expansion.

CURRENT FUNDING FOR GRADUATE MEDICAL EDUCATION

The federal government is the primary funder of GME. In 2012, GME funding was provided by Medicare ($9.7 billion), Medicaid ($3.9 billion), the Veterans Administration ($1.4 billion) and the Health Resources and Services Administration ($0.5 billion).[1] Medicaid funding can be variable; if a state includes GME funding in its budget, the federal government will provide matching funds using a formula based on state per capita income. The number of states including GME funding in their budgets has declined in recent years.[2] Furthermore, since passage of the Balanced Budget Act of 1997, the number of Medicare-funded GME positions has been capped at 1996 levels, and there have been proposals recommending further reduction in Medicare support for GME.[3]

Despite the Medicare cap, the number of residents and fellows has increased since 1997, as new training programs have been created in hospitals that previously had no GME (Medicare will fund

programs in "GME-naïve" hospitals), and hospitals have been able to obtain non-Medicare funding. This growth has occurred disproportionately in subspecialty areas. Between 2003 and 2012, the increase in the number of residents training in core specialty programs was 13.0 percent; for subspecialty programs, the increase was 39.9 percent.[4] Hospitals are able to create funding for these advanced positions, for example, through clinical income provided by faculty, billings that can be submitted by fellows themselves (in programs not accredited by the Accreditation Council for Graduate Medical Education [ACGME]), and through various endowments.[5]

States have attempted and have been sometimes successful at expanding GME by: 1) developing GME programs in core specialty areas; 2) increasing Medicaid funding; 3) proposing new tax structures; and 4) developing partnerships with local foundations and insurance companies. State expansion has principally been in primary care, in rural and underserved areas. Where funding has been realized, it has been for program creation, thus covering accreditation costs, hiring support staff, purchasing new equipment and so forth. Once a hospital has residents enrolled and is receiving Medicare funds, the state program typically ceases to support the hospital (Council on Medical Education Report 7-A-14, Physician Workforce Shortage: Approaches to GME Financing).

PRIVATE OR ALTERNATIVE FUNDING FOR GME

Examples of industry/private support

The Rheumatology Research Foundation, part of the American College of Rheumatology, has administered the Amgen Fellowship Training Award, supported by Amgen, Inc, since 2005.[6] The Foundation is the largest private funding source of rheumatology training and research programs in the United States. In 2014 there were 29 fellows whose funding was supported in part by $50,000 for one year, awarded to the training program.

Similarly, the Neurosurgery Research and Education Foundation of the American Association of Neurological Surgeons acquires funding from several medical device companies to create $50,000 to $75,000 fellowships for clinical training in areas such as spinal surgery, general neurosurgery and endovascular neurosurgery. In the 2012-13 academic year the program sponsored such fellowships at 20 academic medical centers.[7]

GME support from private sources or pharmaceutical companies has created controversy. The American Academy of Dermatology developed a pilot program in 2006 to provide funding to dermatology programs to support 10 residents at $60,000 per year.[8] The program was withdrawn after the pilot, partly because of concerns that the shortage of dermatologists was not dire enough to risk an apparent conflict of interest between education and the pharmaceutical companies involved.[7] Under the Physician Payments Sunshine Act, it is likely that a company will report to the Centers for Medicare & Medicaid Services that payments have been made to individual residents and fellows (equally divided) in a training program that it is supporting, even though payments were indirect and made to the institution. A private firm that assists international medical graduates (IMGs) in finding residency positions has proposed to privately fund positions, although there is no evidence to suggest this has occurred.[9]

The Menninger Clinic, when based in Topeka, Kansas, created a private endowment that aided in financing its GME.[10] Other foundations exist to fund supplemental educational material that may be otherwise inaccessible.[11] The role of foundations in GME has principally been in providing grants for research and community service. Presented with a hypothetical decrease in Medicare funding for GME, over half of designated institutional officials said they would turn to private

philanthropy for assistance in funding resident positions.[12] Foundations would not be a likely resource for ongoing, sustainable GME program expansion on a large scale.

Foreign governments

The Medical and Health Sciences program of the Saudi Arabian Cultural Mission (SACM) places students and physicians in U.S. institutions for pre- and post-graduate education. Established in 2007, the program sponsors over 4,100 students and physicians enrolled in 188 affiliated universities and teaching hospitals. Participating GME programs have resident slots with a separate National Resident Matching Program (NRMP) code to indicate that they are reserved for SACM applicants. These applicants are selected using the same standards as other applicants. Once enrolled in the GME program, SACM scholarships pay for the training of the resident, thus allowing a program to expand even if the institution is over the cap.[13] In 2015, 17 programs participated and 21 Saudi Arabian physicians were matched into positions.[14]

PROPOSED NEW NATIONAL MODELS OF FUNDING

Calls for systems of funding GME that include all who benefit from a well-trained physician workforce, i.e., all payers, are not new.[10] Given the escalating demand for residency positions as a result of the increase in the number of medical school graduates, proposals resulting in increased funding for entry-level positions would enable more physicians to complete the training necessary for licensure and to serve U.S. health care needs. Not all proposals seek to increase training positions.

The Center for American Progress, a nonpartisan policy institute, has proposed a plan that would reduce federal spending on health care, called the Senior Protection Plan. Included in the plan is a suggestion that private insurers should support funding of GME, at $2 per enrollee. This fee would comprise less than 5% of total GME financing. The proposal further suggested that Medicare payments towards GME should be reduced a commensurate amount; therefore, this plan would not necessarily increase the number of training positions.[15]

The GME Initiative, a collaboration of health care consumers and leaders in family medicine residency training, proposes a system that addresses expanding primary care by removing the cap on primary care positions; increasing salaries for primary care residents; expanding Title VII funding for community-based training programs; providing funding directly to primary care programs, educational consortia or non-hospital community agencies; and rewarding programs that produce primary care physicians (assessed five-years post-graduation).[16] This funding is to come through Medicaid, Medicare and all insurers, and not be based on the percentage of Medicare patients a hospital reports or other complex formulas; however, this proposal does not describe how this funding allocation would transpire, other than stating that current GME funding would need to be reallocated to meet workforce needs, and that all payers should contribute.

A more thoroughly described all-payer system would create GME funding by assessing government and non-government health care payers, be it Medicare, Medicaid, private insurers or individuals, at 0.6 percent per encounter.[17] This assessment, which would be collected through a modifier of existing billing codes, would fund the Medical Education Workforce (MEW) trust fund. As an example, total national health expenditures for 2013 from all sources were more than $2.9 trillion. Assessing those expenditures at 0.6 percent would generate $17.5 billion for GME, which is $2 billion more than the GME funds contributed by Medicare, Medicaid, the Veterans Administration, and HRSA in 2012. This assessment, 0.6 percent, approximates the percentage of total national health expenditures spent on GME in 2012. Through the MEW fund, indirect and

direct GME dollars would be replaced with a funds-flow mechanism using fees paid for services by all payers that would provide direct compensation to physicians and institutions that actively participate in medical education. To encourage teaching of medical students, residents and fellows, educators and facilities would receive an incremental educational incentive from the MEW fund. This incentive, also based on a modifier of existing billing codes, would equate to approximately a 10 percent payment per clinical encounter for those physicians engaged in teaching. A facility incentive fund would function like the indirect medical education (IME) dollars currently distributed.

Because of the surplus generated with the MEW fund (compared to 2012 dollars), additional residency positions could be created, even though Medicare and Medicaid contributions would actually be less than before the MEW fund. This model also proposes a "tuition-for-service" program designed to fund the majority of undergraduate medical education, which would assist in creating a physician workforce that is suited to U.S. health care needs. Through eliminating graduation debt, a structured service commitment would be created to better serve communities across all medical specialties and geographies.

PROGRAM EXPANSION FROM THE GROUND-UP

An already established family medicine program at an academic medical center (AMC) has expanded the program by two slots per year into a Federally Qualified Health Center (FQHC) without receiving Medicare funding (as the AMC has reached its funding cap) or state funding. This expansion was the result of combining funding from multiple sources, including the Blue Cross Blue Shield Foundation of North Carolina for startup funds (but not salary support for the residents); a Health Resources and Services Administration (HRSA) Academic Administrative Units (AAU) grant in primary care for resident salaries; and the Duke Endowment for additional salary support for residents for three years to help establish the program. This expansion was assisted by the presence of an established strong infrastructure from the AMC, a well-established FQHC, and a specialty (family medicine) that generates substantial billing, the result of training requirements for family medicine of four to five half days of clinics. Without the various grants (but with the support of existing infrastructure), the costs per resident are estimated to be $60,000 to $70,000 per year, including licensing, meals, etc. Future funding is uncertain, as the grants are time-limited. A grant from the Golden Leaf Foundation will allow the program to expand to three residents per year in the 2016 match. The program director is looking to the University of North Carolina Healthcare System, the North Carolina AHEC (Area Health Education Center) and the state legislature for additional funding.[18]

Based on this experience, the following may serve as some key best practices as well as groundwork for development of model guidelines for GME program expansion and creation.

Suggested first steps for program expansion[18]

- State money may be available. Examine how state Medicaid funds are allocated and whether they support GME, and if so, how the allocation is determined. In states with their own Affordable Care Act Exchanges, there may be an option to use a tax on the exchange to help pay for local GME.
- Perform an exhaustive search of all statewide philanthropic organizations and insurance company foundations that support economic development or health care, including those that address health disparities or other social determinants of health. Make exploratory contact with those groups to discuss program expansion rather than waiting for a Request for Proposals.

- Consider partnering with a large local employer that may see a pipeline of needed primary care physicians as being in their own interest.
- Work with large local hospitals or healthcare systems to understand their dependency on an adequate pipeline of physicians to encourage their participation in support of GME.

Suggested first steps for new program development[19]

- Feasibility Study: An independent feasibility study showing the need for GME, the capacity in the region among one or more hospitals working in partnership to develop and sustain high-quality residency training programs (that could achieve full accreditation from the ACGME), and the financial commitment required from the region to invest "first dollars" potentially matched by state funds.
- Business Plan: A detailed business plan for expanding medical education showing the governance structure for a consortium among one or more hospitals, community health centers, and other partners; the number of residents to be trained in one or more programs; a staffing and financial plan for long term support of quality residency training programs; and an economic impact statement.

ETHICAL AND QUALITY CONCERNS AND AMA POLICY

Concerns about private support of GME have led to the development of principles by the ACGME, which stipulate in part that: 1) sponsoring institutions ensure that residents, fellows, and programs not be identified publically by their funding sources; and 2) sponsoring institutions maintain policies that ensure non-preferential treatment of residents and fellows in the learning environment based upon sources of funding for their positions.[20] Typical policies at GME institutions state that the private funder does not select the trainee to receive the funds, but that the selection is made by the department, division, or program. In addition, the department chair may be named the recipient, who then may be reported as accepting funds under the Sunshine Act. The ACGME has more recently stressed that a reduction in federal support for GME may drive programs to deliberately seek out industry support.[21]

Similarly, the AMA has policy in its *Code of Medical Ethics*, Opinion 8.061 Gifts to Physicians from Industry, stating that "Academic institutions and residency and fellowship programs may accept special funding on behalf of trainees to support medical students', residents', and fellows' participation in professional meetings, including educational meetings, provided the program identifies recipients based on independent institutional criteria; and funds are distributed to recipients without specific attribution to sponsors."[22] AMA also has policy regarding "Residency Positions for Sale," expressing that selection of residents should be based on academic and personal qualifications, and that monetary considerations should not compromise the selection process. (Policy H-310.983)

Private funding of GME programs could theoretically be taken on by a local business or medical group.[23] Care would need to be taken to prevent the effect of a restrictive covenant, in that the funder would require the graduating resident to work for the funder. The ACGME prohibits training programs or institutions to "require a resident/fellow to sign a non-competition guarantee or restrictive covenant."[24]

As programs are expanded or created, ACGME requirements should protect residents and patients from a training situation in which there are not enough patients to guarantee educational quality, insufficient clinic space to practice safely, or lack of appropriate supervision to confirm

competency, as well as protecting residents from exploitation. Enthusiasm for residency program creation or expansion in the face of workforce shortages and physician geographic maldistribution should not diminish the importance of ensuring a safe and productive learning and care environment for both residents and patients. Not all physicians train in ACGME-accredited programs; some non-ACGME-accredited fellowships may be created with expectations of work productivity and revenue generation that exceed what may be safely accomplished.

SUMMARY AND RECOMMENDATIONS

For the most part, private and alternative funding of GME, so far, has been "around the edges." Evidence of full-scale funding of a GME program by foundations or private industry was not uncovered. Funding of educational opportunities or of some portion of a program complement is the more typical route. Foundations have worked together with states to expand GME. The successful program expansion in North Carolina depended upon the contributions of at least three different foundations/philanthropic organizations, as well as support by the sponsoring institution and the clinical site.

For communities, health systems and other entities planning to start or expand their GME activities, this report outlines some steps to consider. These steps will allow planners of new GME programs to consider all currently known options for such funding. Which of these will become a successful financial resource will largely depend on the profile of the local community, the goals of the proposed GME programs and the needs they will meet. This report also encourages sharing of successful, innovative funding proposals for GME. This will allow communities, health systems, training programs and trainees in need of GME slots to benefit from the experience of others.

Proposals to fund GME by all payers could lead to an increase in the number of physicians in GME, and could also alter the specialty and geographic distribution of physicians to be more aligned with the nation's health care needs. Given the scrutiny Medicare funding of GME has received of late, there may now be a greater prospect of developing a new payment system that could fund and shape a more appropriate physician workforce. Whether private payers, both insurers and individuals, can be enjoined to participate in such a system is open to debate, and would likely require legislation. Working towards such a transformation will necessitate a coalition of stakeholders willing to persevere as well as compromise.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 931-I-14 and Resolution 312-A-15 and that the remainder of the report be filed.

1. That our American Medical Association (AMA) reaffirm Policy D-305.967 (8), The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education, which advocates for 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 graduate medical education. (Reaffirm HOD Policy)

2. That our AMA 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. (Directive to Take Action)

3. That our AMA encourage 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. (New HOD Policy)

4. That our AMA encourage organizations with successful existing models to publicize and share strategies, outcomes and costs. (Directive to Take Action)

5. That our AMA encourage 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. (Directive to Take Action)

6. That our AMA encourage 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. (New HOD Policy)

Fiscal note: $5,000.

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