

**ARIZONA HEALTH FUTURES**

*Policy Primers: a nonpartisan guide to a better understanding of key terms and issues in the Arizona health policy landscape.*

## The Tie That Binds: Graduate Medical Education in Arizona

Arizona is making big bets on the future of the health care sector to meet the needs of a growing population. Millions of dollars are being invested in the biosciences industry, hospitals and clinics are in a growth mode, new medical training programs are in the works, and the rush is on to attract the human and financial resources necessary to propel the state to the front ranks of what is projected to become one of the principal drivers of economic vitality, technological innovation and improved quality of life in the future.

All of this depends on a burgeoning infrastructure of human talent. Skilled, creative people are needed to develop a world class health care sector. Chief among these are physicians in a myriad of specialties that require years of advanced training in clinical, real-world settings. Attracting, training, placing and supporting these professionals in positions all across Arizona is the *sine qua non* for the “health” of the state’s health care sector.

This is the province of **Graduate Medical Education (GME)** – the “tie that binds” medical training to actual practice settings. Understanding, supporting and extending GME opportunities in Arizona are critical to the state’s future. The reasons why are the subject of this Arizona Health Futures Policy Primer. ▶ ▶ ▶ ▶ ▶



# Déjà Vu

In January 2003, SLHI published its first policy primer on GME to inform policy leaders of its central importance to the development of Arizona’s physician workforce.<sup>1</sup> Four years later, we have been asked to update that study. Why?

1. Political leadership changes, and so does the knowledge base of issues that is developed over time. We need to occasionally refresh perspectives on critical issues for new audiences and the changing economic, social and political landscape.
2. The flurry of activity in the health care sector over the past four years highlights the importance of strategic planning for a robust professional workforce to meet the state’s development objectives. The issues surrounding the financing and extension of GME opportunities across the state remain. Because of their importance, we bring them to the attention of policy leaders again.

New studies on physician workforce projections in Arizona,<sup>2</sup> along with updated GME financial and program information, provide a critical context for a fresh look at GME and, by extension, at the growing necessity of health care and workforce planning at all levels of public and private governance.

— *Editor*

## What is GME?

The education of physicians is a two-step process:

- **The first step** toward becoming a physician who can practice medicine is completion of an educational program in an accredited medical school. Upon graduation, a physician receives either a Doctor of (Allopathic) Medicine (MD) degree or a Doctor of Osteopathy (DO) degree (see box). A degree, however, does not entitle a graduate to practice medicine.
- **The second step** toward becoming a *practicing* physician is completion of a second phase of education called Graduate Medical Education (GME), followed by taking national exams. Upon passing the exams, a physician applies to the appropriate state board of medical examiners for an MD or DO license to practice in a specific state. By virtue of the license, a physician is then permitted to practice in any area of medicine he/she chooses. (Licensed and practicing MDs outnumber DOs about 10 to 1 in Arizona.)<sup>3</sup>

The GME experience has expanded from what was a one-year “internship” to what is now a minimum three-year residency program called *Post Graduate Year (PGY) 1* (internship year), 2 and 3. Residents are physicians engaged in postdoctoral training in an accredited GME program.

Few physicians go into practice after just one year of training. In some states, boards that oversee physicians have determined that one year of experience is inadequate to be licensed. Most physicians today complete three years of GME in a specific area such as

Family Practice or General Internal Medicine. Others may continue their studies for another three to five years or more to specialize in areas such as surgery, neurology, urology, etc.

Allopathic residency programs accept both MD and DO residents. MDs must take their residency in an allopathic residency program and, upon completion, take the US Medical Licensing Examination (USMLE). DOs who have completed an allopathic residency may choose to take the USMLE exam or the Comprehensive Osteopathic Licensing Examination (COMLEX), which is also taken by DOs who have completed an osteopathic residency program. The examinations come in multiple parts, with portions taken over a period of years. Once completed, the physician applies for a state license to practice medicine.

## A Definition of *the Practice of Medicine*

Not every policy leader is aware that a DO has the same license to practice medicine in Arizona as an MD. These are the relevant state statutes:

“Practice of medicine” means the diagnosis, the treatment or the “correction of or the attempt or the holding of oneself out as being able to diagnose, treat or correct any and all human diseases, injuries, ailments, infirmities, deformities, physical or mental, real or imaginary, by any means, methods, devices or instrumentalities, except as the same may be among the acts or persons not affected by this chapter. The practice of medicine includes the practice of medicine alone or the practice of surgery alone, or both. (ARS 32-1401.21)

“Practice of medicine” or practice of “osteopathic medicine” means all of the following:

- To examine, diagnose, treat, prescribe for, palliate, prevent or correct human diseases, injuries, ailments, infirmities and deformities, physical or mental conditions, real or imaginary, by the use of drugs, surgery, manipulation, electricity or any physical, mechanical or other means as provided by this chapter.
- Suggesting, recommending, prescribing or administering any form of treatment, operation or healing for the intended palliation, relief or cure of any physical or mental disease, ailment, injury, condition or defect.
- The practice of osteopathic medicine alone or the practice of osteopathic surgery or osteopathic manipulative therapy, or any combination of either practice. (ARS 32-01800)

## GME Programs

GME residency programs are offered by a teaching hospital, a consortium of hospitals, academic medical centers, health systems or other institutions. No matter which of these acts to sponsor a program, one hospital or clinical site is designated as the *primary teaching institution*. While residents are located at one primary site, they gain clinical experience in other settings by going on “rotations” to other hospitals, community health centers, clinics and private physician offices.

Within a GME program there may be multiple residencies that focus on a particular area, such as Family Practice or Internal Medicine. Each residency is accredited by either the American Osteopathic Association for DOs or the Accreditation Council for Graduate Medical Education for MDs, according to the specific criteria for that residency.

Medical school graduates must apply to attend a GME program and be chosen through a national “matching process,” where students and teaching hospitals indicate their preference for who attends which program. The result is that both Arizona medical school graduates and graduates of medical schools from across the country come to Arizona for their GME residency experience. Since almost 90 percent of physicians in Arizona graduated from medical schools outside the state, it’s no surprise that the great majority of residents come from elsewhere.<sup>4</sup>

**TABLE 1: Arizona Residency Training Programs 2005**

SPECIALTY	NUMBER OF PROGRAMS	TOTAL APPROVED RESIDENT POSITIONS	ACTUAL NUMBER OF RESIDENTS	PERCENT OF POSITIONS UNFILLED
Anesthesiology	1	30	30	0%
Emergency Medicine	2	78	62	5%
Family Practice	6	135	129	4%
Internal Medicine	5	268	238	11%
Neurosurgery	2	20	16	20%
Obstetrics	3	74	74	0%
Orthopedics	2	30	26	13%
Pathology	2	26	22	18%
Pediatrics	3	133	104	22%
Psychiatry	3	62	57	8%
Radiology	3	44	42	5%
General Surgery	4	118	108	9%
Cardiovascular Disease	3	30	27	10%
Gastroenterology	3	25	21	16%
Neurology	3	36	20	11%
Other	42	157	139	12%
<b>TOTAL</b>	<b>87</b>	<b>1,266</b>	<b>1,115</b>	<b>12%</b>

Source: Accreditation Council for Graduate Medical Education (ACGME).

An estimated 1100-1200 residents participated in GME programs in Arizona in 2006, an increase of roughly 200-300 since 2002.<sup>5</sup> The numbers are sometimes unclear because teaching hospitals may have more approved slots than they do actual residents. Existing teaching hospitals added nearly 200 resident slots while new teaching programs added another 100 slots. Between 70 and 80 slots were closed. Other new GME programs are currently being developed, but there is a lag time of two-four years from start to approval. Table 1 provides an overview of Arizona residency programs in 2005.

## Who Pays for GME?

Funding for GME programs in non-federal teaching hospitals comes from two primary public sources, in addition to support from the hospitals themselves:

1. **MEDICARE.** Approximately \$8 billion was allocated to GME programs nationally in 2006 – an increase of \$1 billion since 2000, or about \$167 million annually. The now defunct Arizona Council for Graduate Medical Education estimated that Arizona’s share of Medicare GME funding was \$56 million in 2000,<sup>6</sup> but to the best of our knowledge, no one has made such an estimate for 2006. Based on the rate of increase nationally, it is not unreasonable to estimate that Arizona’s Medicare support for GME in 2006 was in the neighborhood of \$64 million.

Medicare funding comes in two parts:

- **DIRECT MEDICAL EDUCATION (DME).** Costs directly related to medical education, such as salaries for residents, teaching staffs, etc. The DME payment is based on the “hospital specific per resident amount,” which is periodically updated.
- **INDIRECT MEDICAL EDUCATION (IME).** For the increased costs of having a teaching program in the hospital, such as more diagnostic tests ordered by residents, etc. Studies indicate that teaching hospitals have higher patient costs. Although not all the reasons are fully understood, it is assumed that intensive treatment regimens – in part a reflection of more complex patient care that is often referred to teaching hospitals – are implemented as part of the GME teaching program and result in higher patient care costs than in hospitals without residency programs.<sup>7</sup>

## The Difficulty With Estimating Medicare GME Costs

Hospitals provide Medicare with a cost report of their expenditures related to GME which, together with a count of the number of residents, acts as the basis for Medicare’s determination of the payment due to the hospital. Although Medicare payment may begin with a new program, the total allowable cap will be established in three years, based on the actual number of residents employed at that time. Reconciliation of all payments may not take place until three years after the initial payment.

Cost reports vary significantly between hospitals. Different items are considered part of the costs in each hospital and make direct cost comparisons between GME programs difficult, if not impossible. Information about Medicare GME funding to Arizona hospitals currently is not known and would require an examination of each hospital’s cost report.

Perhaps some standardization in reporting is in order.

2. **MEDICAID.** Arizona receives Federal Medicaid funds for direct medical education costs through the Arizona Health Care Cost Containment System (AHCCCS), the state’s Medicaid program. State Medicaid programs are not required to support GME, but they do so consistently across the country in order to help ensure an adequate workforce and to leverage federal matching funds.<sup>8</sup>

- **EXISTING AHCCCS GME FUNDING: 2006**

In 2006, AHCCCS made payments totaling \$21,820,000 to 13 teaching hospital programs (Table 2). AHCCCS provided a little over \$7 million in state funding to GME in 2006, while the federal match was over \$14.5 million – more than \$2 in federal money for every \$1 invested by the state. The money goes only to those hospitals that serve AHCCCS patients and meet the criteria for accredited GME programs.

- **NEW AHCCCS GME FUNDING: 2007**

In 2006, legislation was passed to expand AHCCCS payments for GME by \$12 million. The state provides \$4 million, which is matched by \$8 million in federal money. These funds are in addition to the money going to the existing 13 programs, which will continue as currently structured.

The \$12 million is to be used to support direct costs for new GME programs and additional resident slots in existing GME programs. Payments will be provided based on a formula developed by AHCCCS administration that reflects the level of service provided to AHCCCS patients in approved GME programs. The state

**TABLE 2: AHCCCS Graduate Medical Education (GME) Payments: Arizona Teaching Hospitals**

GME TEACHING HOSPITALS	TOTAL GME PAYMENT FY 2006	FEDERAL CONTRIBUTION FY 2006 @ 66.98%	STATE CONTRIBUTION FY 2006
Banner Good Samaritan	\$2,484,949	\$1,664,419	\$820,530
Maricopa County Medical Center	7,387,542	4,948,175	2,439,366
Mesa General Hospital	34,790	23,302	11,488
Phoenix Baptist Hospital	160,260	107,342	52,918
Phoenix Children’s Hospital	4,168,155	2,791,830	1,376,325
John C. Lincoln – Deer Valley	16,329	10,937	5,392
Scottsdale Healthcare – Shea	49,770	33,336	16,434
Scottsdale Healthcare – Osborn	179,776	120,414	59,362
St. Joseph’s Hospital – Phoenix	3,091,177	2,070,470	1,020,707
Tempe St. Luke’s	101,622	68,066	33,556
Tucson Medical Center	686,230	459,637	226,593
University Medical Center	3,456,023	2,314,844	1,141,179
Walter Boswell Memorial Hospital	3,378	2,262	1,115
<b>Statewide GME Funding</b>	<b>\$21,820,000</b>	<b>Federal Total \$ 14,615,036</b>	<b>State Total \$7,204,964</b>

Source: Arizona Health Care Cost Containment System (AHCCCS).

will begin to review Medicare cost reports for the number of reported resident slots and the dollars expended for GME programs.

- Programs that were established before July 1, 2006 but not funded as part of the existing payment program (Table 2) will now be eligible to receive DME payments from AHCCCS.
- Any money left after these payments can be used to fund the expansion of programs established and funded on or before October 1, 1999 (i.e., the money can help to expand programs within the 13 existing teaching hospitals receiving funding).
- Monies left over can be used to support new programs created on or after July 1, 2006.
- Payments will begin in 2007 with an estimated \$93,000 in DME support per resident position, close to the national norm of roughly \$100,000 per position. Funding for the existing 13 programs is not apportioned on a per resident basis and will not change except for inflationary increases. The move to a per-resident funding basis, as distinct from a general institutional grant, represents a significant GME policy shift in Arizona.
- In this new funding, monies will also follow the resident on rotations outside the hospital so that clinics and other hospitals will receive funding for that resident during their time at that institution.
- \$1 million will be used to support the development of new programs through as much as a \$500,000 interest-free loan to hospitals developing a new GME program in rural areas. The loan will be paid back once Medicare GME payments begin to flow to the hospital.

**3. HOSPITAL REVENUES.** Teaching hospitals support their GME programs through revenue generated by their fees for hospital services, grants and other fund raising efforts. No specific GME cost recovery scheme is built into the payments made by any payers other than Medicare or Medicaid.

## *Medicare/Medicaid Funding of GME in Arizona 2006*

SOURCES OF FUNDING	AMOUNT
Medicare-Indirect Medical Education (IME) payments (estimate)	\$48 million
Medicare Direct Medical Education (DME) payments (estimate)	\$16 million
Medicaid (AHCCCS)	
State (actual)	\$7.2 million
Federal (actual)	\$14.6 million
<b>TOTAL</b>	<b>\$85.8 MILLION</b>

## The Case for GME Public Support

Public support for GME is fundamentally both an ethical and economic issue:

- On the *economic* side, GME is a service that benefits the public at large. It cannot be produced “at the appropriate level in the private market because of the difficulty in pricing it.” Further, “although the community at large, including future patients and physicians, benefits from medical education, it is impossible to charge future beneficiaries.” Hence, “left to itself, the private market will under produce GME.”<sup>9</sup> Without some kind of public subsidy, the costs of training are too great for many physicians to pay entirely without incurring large debts, especially if they choose to practice in the less lucrative areas of family practice and internal medicine, among other specialties.
- On the *ethical* side, the vast majority of people in the U.S. expect health providers to be “charitable” and act on behalf of the public good. Medicine may well be “just

another business” in many respects, but it remains one in which medically necessary services are provided to those who are often unable to pay for them. The central point of contention is not whether such services should continue to be provided, but how their costs should be distributed in a fair, efficient and effective manner.

### GME Residents Provide a Public Good

Medical residents serve all patients. It is difficult and costly to attempt to exclude patients whose insurance, health plans or out-of-pocket payments do not support GME costs, not to mention those patients with no visible means of payment at all. The result is that it is easier to provide the residents as a *public good* to all those seen in a teaching hospital rather than to struggle with restrictions on their service. This public good, in turn, is supported by public (tax payer) support of resident salaries that are adequate but less than what would be required if the resident were not still in a teaching/learning setting.

## Who Should Pay for GME?

Most observers agree that the present means of financing GME primarily through Medicare and Medicaid is fraught with problems. Where they disagree is what to do about it.

- Some favor an “all payer” system that would place a surcharge on private insurance premiums in addition to Medicare and Medicaid funding. Everyone should pay their fair share of medical education costs.
- Some buy the tax financing argument, but think it should come from general funds and be forced to compete with other claims on public funds in an annual appropriation process.
- Some believe that a surcharge on premiums is just another tax hike, and an aggressive one at that.
- Some argue that there is little justification for public support of GME, because physicians are among the highest paid of all professionals, and there are more qualified applicants for medical schools than spaces to accommodate them.

Despite their differences, few people advocate eliminating federal financing of GME. The issue is finding the proper balance between federal support and other public or private means.



## **GME Residents Serve the Needy and Expand Available Access to Physicians**

Funding for GME in non-federal teaching hospitals is derived primarily from two public sources: Medicare and Medicaid. For the most part, private payers do not explicitly participate in funding GME. Other funds are allocated to GME, but these two public programs, which are focused on care for the elderly and the most vulnerable (in part) in the U.S. population, are the financial foundation for government support of GME. Residents serve as a valuable resource for care and a significant link in the “safety net” of services established to serve these populations. As private employer-sponsored insurance coverage continues to decrease and the number of uninsured in Arizona increases, this resource for care becomes ever more important.

## **GME Programs Help to Attract Physicians to Arizona**

Physicians who train in Arizona, either at a medical school or for their GME experience, have a higher likelihood of staying in the state. Although numbers vary from year to year, studies suggest that 40-50 percent remain in the state to practice.<sup>10</sup> Even with the current and planned expansion of medical education programs in Arizona, we will continue to need to import the majority of practicing physicians from outside the state. It stands to reason that the availability of new residency slots, and the requisite institutional infrastructure to support them, will help to attract physicians to the state and ensure an adequate workforce to meet the growing demand for health care services. Increased support for GME programs, as well as more targeted residency programs, can also help to address workforce shortages in selected specialties and in rural areas of the state, which historically have had trouble attracting and retaining physicians.

## **GME Programs Enhance a Climate for Quality Care and Research Development**

The rigors of an educational program in a teaching hospital or other clinical settings establish an attitude toward excellence and quality that permeates the facility and the professionals practicing within it. This translates to a standard of care that demands licensed practitioners stay current in clinical information and practice so they can teach and serve as role models for residents – a climate that serves them and their patients well. In rural areas, it offers professionals a chance for collegial relationships and sharing that might not otherwise be possible without the links to academic centers of excellence.

Enhanced GME settings can also focus attention on, and participation in, clinical research. For some, this exposure begins a life-long involvement in research. Arizona’s investments in medical education and its support of an evolving bioscience industry are strengthened by well developed GME programs, since research has to translate to real life clinical settings and can be facilitated in teaching hospitals and other clinical sites.

Finally, GME funding provides more than just money. It frees up clinical faculty to work with residents. If outside funding sources are not available, clinical faculty are drawn away from teaching activities to patient care duties in order to generate revenue to support the GME program. To the extent that the need to do this is reduced, clinical faculty can spend more time teaching residents.

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# The Future of GME in Arizona

## Funding

### Medicare

The 1997 Balanced Budget Act reduced Medicare IME payments for GME and capped residency slots at 1996 levels, thereby limiting the amount of DME that Medicare will support. As a result, Arizona GME programs were uncertain whether they should, or could afford to, exceed the established caps. Arizona must continue to expand its GME programs simply to keep pace with rapid population growth and the demand for services. GME programs have responded to the demand by expanding residency slots above the Medicare allocation, with hospitals absorbing the additional costs. Although Medicare is not supporting this growth, it nevertheless remains a significant source of funding for GME programs. The issue, of course, is where support for this necessary expansion will come from in the future.

### Medicaid

AHCCCS GME funding has remained essentially fixed except for inflationary increases. Although hospitals have expanded GME programs to meet physician and specialty demand, the costs are significant and particularly hard to meet for small and rural hospitals. The legislature responded in 2006 with an additional \$4 million State appropriation that will leverage an \$8 million match available from the federal Medicaid program. These new federal Medicaid GME dollars and existing GME dollars require a continuing investment by the state. Without it, Arizona would lose almost \$23 million just in AHCCCS DME funding. In our opinion, this is a good return on the state's investment.

### The Future Without AHCCCS Support

If AHCCCS GME payments were to cease, hospitals would continue to receive their Medicare IME and DME funding at or above the estimated 2006 level of \$64 million. Regardless, these capped funds could not support the full costs of GME programs, meaning programs would have to downsize or close. To the extent that state budgets and matching funds for AHCCCS GME payments are limited either by necessity or choice, GME programs in Arizona would shrink, since it is doubtful hospitals could suddenly absorb the costs of programs without seeking significant GME payments from other sources, including private payers – a scenario that is unlikely to occur. Residents unable to complete an expected minimum three years of residency at their primary teaching institution might not be able to find a replacement slot, although teaching hospitals are mandated by the American Council on Graduate Medical Education to pay the resident's salary if they do transfer to another institution.

## FINANCIAL LEVERAGE

*Beginning in 2007, AHCCCS investment of \$11.2 million for GME leverages slightly over \$2 (\$22.6 million) for every \$1 of state investment. If one adds Medicare payments that come to Arizona because of its GME programs, the return is almost 9 to 1.*

## Policy

### Spreading Financial Responsibility for GME

Although GME programs and residents provide a public good, their level of funding is being challenged as the costs of medical care and medical education continue to rise, and as public programs attempt to constrain their own expenditures. Other payers do not make significant contributions toward teaching hospital costs for GME programs, yet their patients use the services. Given the discounted rates negotiated by insurance companies and health plans, can it be assumed their payments provide the hospital any margin of support for GME? Should other payers absorb some of the GME costs? If so, should it be through an “all payer” surcharge on private insurance premiums? Should fees for hospital services or contracted services include a specific charge for GME for each patient admission? There is little consensus and certainly no eagerness to be responsible for added costs. However, the policy issue clearly needs to be addressed.

### Balancing GME with State Health Policy Interests

Should the State (or federal government) try to influence the type and number of residents available to its people in accordance with an analysis of projected workforce needs? Some states, for example, earmark GME funds for training in family medicine or other specialties in underserved areas (rural, low income, etc.). Until recently, Arizona, which arguably lacks any coherent and explicit state health workforce policy, has operated on the principle that GME funding is too blunt an instrument to try to address specific physician workforce needs, since so many other personal and market factors influence what hospitals and residents might pursue and desire at any one point in time.

Nevertheless, given the State’s growing level of interest in, and financial support of, GME and other health workforce programs (e.g., nursing education), the question remains whether GME ought to be tailored to provide specific incentives for those residents and teaching programs that share similar interests with the State.

### Directing Resources to Underserved Communities

This question is particularly relevant because of the new State monies appropriated for GME and continuing efforts to expand that support. GME programs established before July 1, 2006, are increasing in size, making it uncertain if, or how much, money will reach future programs, since the appropriation is distributed to existing programs before those yet to be created. This does not mean existing residency programs don’t contribute to and serve the State’s interests, but it does mean that selected State interests may not be well reflected in program growth already under way.

Of particular concern in Arizona is the need to provide access to physicians of a particular type in underserved areas of cities and rural communities to ensure that AHCCCS-eligible members can receive care in their home communities. Establishing or expanding GME programs and the pool of residents would provide a potential physician resource. Targeted incentives might be effective in this regard.

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## A Forum for GME Planning

Future discussion of policy issues like spreading financial responsibility for GME and aligning it with state workforce needs should include all relevant stakeholders if positive results are to be achieved. From 1990 to 2000, the Arizona Council for Graduate Medical Education (AzCGME), provided research and analysis of GME issues and made recommendations on GME policy changes. Its members included allopathic and osteopathic medical schools and universities, teaching hospitals and consortia, and medical and hospital associations involved with GME in the state. Unfortunately, the Council ceased to exist in January 2000, and with it a forum for a broad cross-section of stakeholders invested in GME.<sup>11</sup>

AHCCCS stepped into this planning vacuum and convened stakeholder meetings to discuss the new GME funding and how it should be optimally allocated. The meetings helped inform and shape the rules developed and discussions about any future funding efforts. Although there is no specific requirement for such advisory activities, AHCCCS served the state well by convening the group and may wish to continue to do so.

The Phoenix Area Medical Education Consortium was created in 1995 to enhance the graduate medical education opportunities in Phoenix. It was a member of AzCGME and later evolved into a statewide organization, the Arizona Medical Education Consortium (AzMEC) formed in 2003. It combines the academic resources of the University of Arizona College of Medicine with the clinical resources of teaching hospitals in Phoenix, Scottsdale and Tucson, and is a clinical partner with the Arizona state initiative in biomedical research. AzMEC provides an important link and resource for GME, but it does not include all the stakeholders. Its expansion might provide another alternative for a GME planning forum.

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## Recommendations

### Continue to Monitor Arizona Physician and Resident Supply

The careful monitoring and analysis of physician workforce supply in Arizona – indeed, for *all* health workforce supply issues – is vital for developing policies and programs to improve or enhance it. In our opinion, there are strong arguments for *core public funding* in this area, given its vital importance to state health care and economic development issues.

### Establish a Continuing GME Forum

Although there are forums for considering various aspects of the issues confronting GME, an organized all-inclusive forum of stakeholders is needed to clarify issues and advocate for, and advance an understanding of, GME in Arizona. It should include both allopathic and osteopathic GME programs. Going one step further, we believe there are good reasons for creating an ongoing *Health Planning Forum* in Arizona that would incorporate GME, other healthcare workforce issues, facilities development, access, cost and quality issues, and other considerations important to the future development of the State.

### Advance Understanding of GME at the Arizona Legislature

Investment in GME by the State now and in the future is a necessary and reasonable state investment. It is important that members of the Arizona State Legislature understand the value of that public investment and the role GME plays in the delivery of necessary health services in the State.

### Continue AHCCCS Funding of GME

AHCCCS funding of GME is essential to the survival of strong GME programs and expansion of the physician supply in the Arizona. Assuming Medicare continues to cap its GME investment, AHCCCS support will become an even more important component in the future. Properly designed and promoted, GME provides an effective way to expose physicians to Arizona and entice them to practice medicine here.

### Offer Incentives to Keep Physicians in Arizona After Completing GME

The State should consider the creation of a loan repayment program for residents who choose to locate in Arizona, similar to what is done for medical school. With the expansion of programs and experience in underserved rural or semi-rural areas, Arizona could encourage retention in the state through this or other incentives.

### Expand Loan Repayment/Forgiveness Programs to Encourage the Development of GME

Although a loan repayment program is beginning under AHCCCS, consider expanded funding and even loan forgiveness for hospitals able to demonstrate that reimbursement from Medicare and Medicaid is insufficient to cover start up costs.

## Further Sources of Information on GME

- ▶ Arizona Health Care Cost Containment System:  
[www.ahcccs.state.az.us](http://www.ahcccs.state.az.us)
- ▶ Arizona Medical Education Consortium:  
[www.azgme.org](http://www.azgme.org)
- ▶ Accreditation Council for Graduate Medical Education (Responsible for accreditation of post-MD medical training programs in the United States):  
[www.acgme.org](http://www.acgme.org)
- ▶ Council on Graduate Medical Education (Congressionally authorized):  
[www.cogme.gov](http://www.cogme.gov)
- ▶ U.S. Department of Health and Human Services, Health Resources Services Administration, Bureau of Health Professions:  
[www.hrsa.gov](http://www.hrsa.gov)
- ▶ Medicare Payment Advisory Commission:  
[www.medpac.gov](http://www.medpac.gov)
- ▶ American Academy of Medical Colleges (AAMC):  
[www.aamc.org](http://www.aamc.org)
- ▶ American Association of Colleges of Osteopathic Medicine (AACOM):  
[www.aacom.org](http://www.aacom.org)
- ▶ Fellowship and Residency Electronic Interactive Database (FREIDA), American Medical Association (Lists allopathic residencies in Arizona by type of residency and number of slots available):  
[www.ama-assn.org](http://www.ama-assn.org)
- ▶ American Osteopathic Association (Responsible for accreditation of post-DO medical training programs in the United States and approved internships and residencies. Lists existing osteopathic residencies in Arizona by type of residency and number of slots available):  
[www.opportunities.osteopathic.org](http://www.opportunities.osteopathic.org)

## References

- 1 Lockhart, C., *Graduate Medical Education*, an SLHI Policy Primer, January 2003, [www.slhi.org](http://www.slhi.org).
- 2 See Johnson, W.G., et al., *The Arizona Physician Workforce Study. Part I: The Numbers of Practicing Physicians 1992-2004*. 2005, Arizona State University, Health and Disability Research Group, School of Health Management and Policy, W. P. Carey School of Business.
- 3 Ibid.
- 4 For more information on Arizona residency programs and physician workforce issues in general, see Rimsza, M., et al, *The Arizona Workforce Study: Part II, 1994-2005*, 2006, Arizona State University, Health and Disability Research Group, School of Health Management and Policy, W. P. Carey School of Business.
- 5 Lockhart, C., op.cit.
- 6 Arizona Council for Graduate Medical Education, State of the State, January, 2000.
- 7 Description of the rationale for Medicare IME payments by Secretary of the Department of Health and Human Services, *Hospital Prospective Payment for Medicare: A Report to Congress*, December 1982, pages 48-49.
- 8 Henderson, T.M., *Medicaid Support for Graduate Medical Education*, The Center for the Health Professions, 1998, University of California, San Francisco.
- 9 “State and Managed Care Support for Graduate Medical Education: Innovations and Implications for Federal Policy,” *Council on Graduate Medical Education*, July 2004.
- 10 See Johnson, et al, op. cit., and Rimsza, et al., op. cit. for a more extensive discussion of physician supply and medical training patterns in Arizona.
- 11 AzCGME guiding principles on GME payments and recommendations for the future were presented in SLHI’s January 2003 GME policy primer, Lockhart, C. op.cit.

Understanding, supporting and extending opportunities in *Graduate Medical Education* – the “tie that binds” medical training to actual practice settings – are critical to Arizona’s future.

## ***Our Mission***

*To improve the health of people and their communities in Arizona, with an emphasis on helping people in need and building the capacity of communities to help themselves.*

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St. Luke's Health Initiatives is a public foundation formed through the sale of the St. Luke's Health System in 1995. Our resources are directed toward service, public education and advocacy that improve the health of all Arizonans, especially those in need.

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