2ND CONGRESS
1ST SESSION

S. 15

To reverse the freezing of Medicare funding for increased physician residency positions in the United States for the purpose of addressing the shortage in medical professionals available to practice, escpecially in the severely deficient fields of primary care and general surgery; to provide for limitations on the increases in residency positions available per fiscal year; to initiate studies on how to properly address deficiencies in the medical field in certain specialities and underserved communities; and for other purposes.

IN THE SENATE OF THE UNITED STATES

DECEMBER 31, 2013

Mr. MENON (for himself and Mr. AKHTAR) introduced the following bill; which was referred to the Committee on Health, Education, Labor, and Pensions for a period to be subsequently determined by the President Pro Tempore, for consideration of such provisions as fall within the jurisdiction of the committee concerned.

A BILL

To reverse the freezing of Medicare funding for increased physician residency positions in the United States for the purpose of addressing the shortage in medical professionals available to practice, escpecially in the severely deficient fields of primary care and general surgery; to provide for limitations on the increases in residency positions available per fiscal year; to initiate studies on how to properly address deficiencies in the medical field in certain specialities and underserved communities; and for other purposes.

1 *Be it enacted by the Senate and House of*
2 *Representatives of the United States of America in*
3 *Congress assembled,*
4 **SECTION 1. SHORT TITLE.**

5 This Act may be cited as the "National Physician
6 Residencies Expansion Act".
7 **SEC. 2. FINDINGS.**
8 Congress finds the following—
9 (1) In the United States, students training to be physicians
10 attend four years of medical school, typically paying most of
11 those costs directly or through loans. Upon graduation, they
12 receive their M.D. or D.O. degrees and finish their preparation
13 as residents. During this period, they see and treat patients
14 under the supervision of more seasoned physicians. This
15 training usually takes place in hospitals. On average, physicians
16 spend four years in graduate training, although the length of
17 training in highly specialized fields is several years longer.
18 (2) In 1997, Medicare funding for increases in the number of
19 residency positions in hospitals across the nation was
20 eliminated. The Department of Health and Human Services
21 (HHS), through the Centers for Medicare and Medicaid Services,
22 is the single largest funder of graduate medical education
23 (GME). This is the training that medical school graduates
24 receive as residents in more than 1,000 of the nation's
25 hospitals, known as "teaching" hospitals. These trainees are a
26 key part of the labor supply at these hospitals. As a result, this
27 cut in funding to any increase in residency funding has severely
28 limited the number of physicians able to receive the necessary
29 training in order to practice in the United States, and address
30 the rising need for physicians amid a growing and aging
31 population with more and more health needs. The number of

32 physicians and the ratio of physicians to general population
33 have increased over the past several decades. However, with
34 the expansion of insurance coverage under the Affordable Care
35 Act, there are concerns about whether the number of
36 physicians will be sufficient to meet the needs of newly covered
37 individuals.
38 (3) Despite broad agreement on the need for growth in the
39 primary care workforce, the number of specialist physicians still
40 outweighs the number of primary care doctors by about two to
41 one. This contrasts with the situation in many other countries,
42 where numbers of primary care physicians and specialists are
43 roughly equal. The relatively weak role of primary care in US
44 health care may help explain why other countries achieve
45 better and more cost-effective health outcomes than the United
46 States. There are several reasons for the disparity in numbers
47 of specialists versus primary care providers: Specialists earn
48 considerably more than do primary care doctors, and specialists
49 often perceive the work they do for patients as being more
50 complex and intellectually challenging than primary care. A
51 severe deficiency is present in the United States for primary
52 care physicians and general surgeons, exacerbated every year
53 by the lack of opportunities available to pursue these
54 specialities.
55 (4) Many people in the United States, especially in rural areas,
56 do not have sufficient access to medical specialists. Large
57 graduate medical education payments from the Federal
58 government, especially through Medicare, to teaching hospitals

59 that are located primarily in urban areas may be exacerbating
60 the maldistribution problem, because physicians tend to
61 practice where they do their residencies.
62 (5) There is a large number of foreign physicians who have
63 immigrated to the United States who are unable to gain a
64 residency in order to practice in the United States due to the
65 lack of residency positions available. This means that there is a
66 large number of physicians in the country currently that are
67 unable to practice. It has not been confirmed exactly how many
68 immigrant doctors are in the United States and not practicing,
69 but some other data points provide some evidence. Each year
70 the Educational Commission for Foreign Medical Graduates, a
71 private nonprofit, clears about 8,000 immigrant doctors (not
72 including the American citizens who go to medical school
73 abroad) to apply for the national residency match system.
74 Normally about 3,000 of them successfully match to a
75 residency slot, mostly filling less desired residencies in
76 community hospitals, unpopular locations and in less lucrative
77 specialties like primary care. Over the last five years, an
78 average of 42.1 percent of foreign-trained immigrant physicians
79 who applied for residencies through the national match system
80 succeeded. That compares with an average match rate of 93.9
81 percent for seniors at America’s mainstream medical schools.
82 **SEC. 3. SCOPE AND PURPOSE.**
83 The purpose of this Act is to amend Section 1886(h)(4) (42
84 U.S.C. 1395ww(h)(4)) and all other relevant Federal law in
85 order to reverse the freezing of Medicare funding for increased

86 physician residency positions in the United States for the
87 purpose of addressing the shortage in medical professionals
88 available to practice, escpecially in the severely deficient fields
89 of primary care and general surgery; to provide for limitations
90 on the increases in residency positions available per fiscal year;
91 to initiate studies on how to properly address deficiencies in the
92 medical field in certain specialities and underserved
93 communities; and for other purposes.

94 **SEC. 4. DEFINITIONS.**

95 In this Act:

96 (1) Primary care.—

97 The term "primary care" means family medicine, general
98 internal medicine, general pediatrics, preventive medicine,
99 obstetrics and gynecology, general surgery, and psychiatry.

100 (2) General surgery.—

101 The term "general surgey" means the treatment of injury,
102 deformity, and disease using operative procedures defined as
103 surgical treatment, in order to provide primary care.

104 (3) Hospital.—

105 The term "hospital" means a hospital or other applicable health
106 care providing insitution that receives payments under Medicare
107 in order to instute residency programs to train physicians.

108 (4) Residency.—

109 The term "residency" means a stage of graduate medical
110 education and training conducted in a certain specialty required
111 for physicians to gain licensing and the right to practice in that

112 given specialty; in this Act, the term shall refer to those
113 residencies funded through the Medicare program.

114 (5) Resident limit.—

115 The term "resident limit" means the limitations on the number
116 of residency positions that may be accorded in general or to a
117 given hospital as consistent with the terms of this Act and other
118 applicable law, rules, and regulations.

119 **SEC. 5. RESTORING THE ABILITY OF HOSPITALS TO**
120 **INCREASE THE NUMBER OF PHYSICIAN RESIDENCY**
121 **POSITIONS AVAILABLE THROUGH MEDICARE.**

122 Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4))
123 subparagraph (F) is amended to read:

124 '(F) Number of residents in allopathic and osteopathic
125 medicine.—

126 Such rules shall provide that for purposes of a cost
127 reporting period beginning on or after October 1, 1997,
128 the total number of full-time equivalent residents
129 before application of weighting factors (as determined
130 under this paragraph) with respect to a hospital's
131 approved medical residency training program in the
132 fields of allopathic medicine and osteopathic medicine
133 shall be allowed to exceed the number of such full-time
134 equivalent residents for the hospital's most recent cost
135 reporting period ending on or before December 31,
136 1996.'

137 **SEC. 6. LIMITATION ON INCREASE PER YEAR**
138 **AND PROVISION BASED ON SPECIALTY NEEDS.**

(a) Limitation—

The aggregate number of increases in the number of residencies funded shall not exceed 3,000, 1,000 of which shall be reserved for primary care and general surgery residencies only, in a given fiscal year. A hospital may not receive more than 75 full-time equivalent additional residency positions under this section for any fiscal year.

(b) Application of per resident amounts for primary care and nonprimary care—

With respect to additional residency positions in a hospital attributable to the increase provided under this Act, a hospital receiving more than 10 residency positions may not receive more than 70 percent of the increased number (over 10) of allotted residencies to that hospital that are not primary care or general surgery residencies.

(c) Providing for adequate primary care and general surgery residencies—

(1) A hospital applying for an increase in residency positions under the terms of this Act is not eligible for an increase in residency funding under this Act unless the amount by which the reference resident level of the hospital exceeds the otherwise applicable resident limit is not less than 10 and the hospital trains at least 25 percent of the full-time equivalent residents of the

hospital in primary care and general surgery (as of the date of enactment of this paragraph); and

(2) shall continue to train at least 25 percent of the full-time equivalent residents of the hospital in primary care and general surgery for the applicable residency period beginning on such date. In the case where the Secretary determines that a hospital described in this section no longer meets the requirement of this subclause, the Secretary of Health and Human Services may reduce the otherwise applicable resident limit of the hospital by the amount by which such limit was increased under this subparagraph.

SEC. 7. TRANSPARENCY IN GRADUATE MEDICAL EDUCATION FUNDING.

(a) In General—

Not later than 2 years after the date of the enactment of this Act, and annually thereafter, the Secretary of Health and Human Services shall submit to Congress and the National Health Care Workforce Commission a report on the graduate medical education payments that hospitals receive under the Medicare program. The report shall include the following information with respect to each hospital that receives such payments:

(1) The direct graduate medical education payments made to the hospital under section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)).

191 (2) The total costs of direct graduate medical education
192 to the hospital as reported on the annual Medicare Cost
193 Reports.
194 (3) The indirect medical education payments made to
195 the hospital under section 1886(d)(5)(B) of such Act
196 (42 U.S.C. 1395ww(d)(1)(B)).
197 (4) The factors contributing to the higher costs of
198 patient care provided by the hospital, including—
199 (A) the costs of trauma, burn, other standby services;
200 (B) translation services for disabled or non-English
201 speaking patients;
202 (C) the cost of uncompensated care;
203 (D) financial losses with respect to Medicaid patients;
204 and
205 (E) uncompensated costs of clinical research.
206 **SEC. 8. STUDY AND REPORT ON PHYSICIAN**
207 **WORKFORCE.**
208 (a) Study—
209 The Comptroller General of the United States shall
210 conduct a study on the physician workforce. Such
211 study shall include the identification of physician
212 specialties for which there is a shortage, as defined by
213 the Comptroller General.
214 (b) Report—
215 Not later than January 1, 2014, the Comptroller
216 General shall submit to Congress a report on the study
217 conducted under subsection (a), together with

218 recommendations for such legislation and
219 administrative action as the Comptroller General
220 determines appropriate.
221 **SEC 9. STUDY AND REPORT ON STRATEGIES FOR**
222 **INCREASING DIVERSITY.**
223 (a) Study—
224 The Comptroller General of the United States shall
225 conduct a study on strategies for increasing the
226 diversity of the health professional workforce. Such
227 study shall include an analysis of strategies for
228 increasing the number of health professionals from
229 rural, lower income, and under-represented minority
230 communities, including which strategies are most
231 effective for achieving such goal.
232 (b) Report—
233 Not later than 2 years after the date of enactment of
234 this Act, the Comptroller General shall submit to
235 Congress a report on the study conducted under
236 subsection (a), together with recommendations for
237 such legislation and administrative action as the
238 Comptroller General determines appropriate.
239 **SEC. 10. APPROPRIATIONS.**
240 The Department of Health and Human Services,
241 through the Centers for Medicare and Medicaid
242 Services, shall be responsible for regulating the
243 increase in allopathic and osteopathic residencies,
244 overseeing the terms of this Act, and incurring any

245 expenses associated with the increase in approved
246 allopathic and osteopathic residencies under the terms
247 of this Act. The Comptroller General shall be
248 specifically responsible, in collaboration with the
249 Department of Health and Human Services, for
250 implementing and funding §8 and §9 of this Act.
251 **SEC. 11. EFFECTIVE DATE.**
252 All sections of this Act shall go into effect six months after
253 passage.

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