

# **THE RESIDENT PHYSICIAN SHORTAGE REDUCTION ACT OF 2009**

**S. 973 introduced on May 5, 2009, by Sen. Bill Nelson (D-Fla.), Sen. Charles Schumer (D-N.Y.), and Majority Leader Harry Reid (D-Nev.)**

**H.R. 2251 introduced on May 5, 2009, by Rep. Joseph Crowley (D-N.Y.), Rep. Kathy Castor (D-Fla.), and Rep. Kendrick Meek (D-Fla.)**

## **Purpose**

This bill will enhance America's health care infrastructure by expanding the number of Medicare-supported physician residency training positions by 15 percent, or roughly 15,000. In 1997, the Balanced Budget Act froze the number of residents that a hospital could claim Medicare payment for, based on the number of residents that each hospital trained in 1996. Between 1980 and 2005, the nation's population grew by 70 million people—a 31 percent increase. By 2030, as baby boomers age, the number of Americans over age 65 will double from 35 million to 71 million. These changes will significantly increase the demand for physicians' services. In 2007, the Council on Graduate Medical Education recommended increasing Medicare-funded residency positions by at least 15 percent to meet growing demand. In light of efforts to greatly expand health coverage as part of health care reform efforts, this need is even more acute. This legislation would meet that need by expanding Medicare-supported residency slots with preferences for primary care, training in community health centers (CHC), and other community-based training. It would also make changes to current rules that limit a hospital's flexibility in training its residents in nonhospital settings. Finally, it would allow residency slots in hospitals that close to be redistributed to nearby teaching hospitals so that these slots are not completely eliminated upon hospital closure, as they are currently.

## **Section 1. Short Title "Resident Physician Shortage Reduction Act of 2009"**

**Section 2. Distribution of Additional Residency Positions** The Secretary of Health and Human Services will reduce the resident cap at hospitals by the number of slots that have remained unused over the past five-year period. The Secretary will then distribute a number of additional slots equal to 15 percent of the current number of residency slots in the United States. Two-thirds of these slots will be given to hospitals applying for slots for new or expanded residency programs. Preference will be given to hospitals applying for primary care or general surgery slots, or slots that emphasize community-based training; further preference will be given to hospitals in states with fewer Medicare-sponsored residency slots than medical students, and to hospitals in states with low resident-to-population ratios. The remaining one-third of these slots will be allocated proportionately to hospitals operating over their caps, as long as they are training at least 25 percent of their residents in primary care or general surgery.

**Section 3. Counting Resident Time in Outpatient Settings** Currently, the time residents spend training in nonhospital settings can be counted as long as the hospital pays “all or substantially all” of the training costs at that site and the resident spends his or her time in patient care activities. This section would clarify the meaning of “all or substantially all” to allow for the counting of patient care activities as long as the hospital continues to incur the costs of the stipends and fringe benefits of the resident during the time the resident spends training in the nonhospital setting.

**Section 4. Rules for Counting Resident Time for Didactic and Scholarly Activities and Other Activities** The Medicare program currently does not reimburse teaching hospitals with direct GME payments for the time residency trainees spend in educational activities in nonhospital settings. Furthermore, Medicare is not permitted to reimburse teaching hospitals with indirect medical education (IME) payments for the time residency trainees spend in these educational activities in any setting. This section would permit Medicare indirect graduate medical education (GME) reimbursement for educational activities that occur in the hospital as well as Medicare direct GME reimbursement for educational activities that occur in clinical nonhospital settings (including CHCs and other community-based ambulatory care sites).

**Section 5. Preservation of Resident Cap Positions from Closed and Acquired Hospitals** The closure of teaching hospitals significantly affects the communities served by those hospitals. When a teaching hospital closes, the ability of any entity to obtain Medicare reimbursement on a long-term or permanent basis for the residency slots at the closed hospital ends. This section would allow other providers to receive Medicare payment for same number of residents as were previously reimbursed at the closed facility. When a facility closes, its residency slots would be preferentially allocated to other hospitals in the same geographic area or to providers outside of the impacted geographic area only if there is not sufficient interest or need for the slots in the same geographic area as the closed hospital. Similarly, when a teaching hospital in bankruptcy is acquired, the acquiring hospital would be permitted to continue to train resident physicians from the acquired teaching hospital to avoid disruption to the community and the trainees.