FACTSHEET

The Resident Physician Shortage Reduction Act of 2015

BACKGROUND

The Balanced Budget Act of 1997 imposed caps on the number of residents for which each teaching hospital is eligible to receive Medicare direct graduate medical education (DGME) and indirect medical education (IME) reimbursement. These caps have remained in place and have generally only been adjusted as a result of certain limited and one-time programs.

AHA POSITION

The AHA supports passage of the Resident Physician Shortage Reduction Act of 2015 (H.R. 2124/S. 1148), which would increase the number of residency positions eligible for Medicare DGME and IME support by 15,000 slots above the current cap.

DISTRIBUTION METHODOLOGY FOR ADDITIONAL SLOTS

H.R. 2124, introduced by Reps. Joe Crowley (D-NY) and Charles Boustany (R-LA), would increase the number of residency slots nationally by 3,000 each fiscal year from 2017 through 2021:

- A hospital may not receive more than 75 slots in any fiscal year unless the Department of Health and Human Services (HHS) Secretary determines there are remaining slots available for distribution.
- One-third of the new residency slots would be available only to teaching hospitals already training at least 10 residents in excess of their cap.
- In determining which hospitals would receive slots, the HHS Secretary must consider the likelihood of a teaching hospital filling the positions and would prioritize teaching hospitals in the following order:
    1. Hospitals in states with new medical schools
    2. Hospitals in training partnerships with Veterans Affairs medical centers
    3. Hospitals that emphasize training in community-based settings or hospital outpatient departments
    4. Hospitals eligible for electronic health record incentive payments
    5. All other hospitals

S. 1148, introduced by Sens. Bill Nelson (D-FL), Charles Schumer (D-NY) and Harry Reid (D-NV), would increase the number of residency slots nationally by 3,000 each fiscal year from 2017 through 2021:

- A hospital may not receive more than 75 slots in the aggregate from 2017 through 2021, unless the HHS Secretary determines there are remaining slots available for distribution.
- In determining which hospitals would receive slots, the HHS Secretary must consider the likelihood of a teaching hospital filling the positions and would prioritize teaching hospitals in the following order:
    1. Hospitals in states with new medical schools
    2. Hospitals already training residents in excess of their cap
    3. Hospitals in training partnerships with Veterans Affairs medical centers
    4. Hospitals that emphasize training in community-based settings or hospital outpatient departments
    5. Hospitals eligible for electronic health record incentive payments
    6. All other hospitals

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Requirements for Additional Slots

Both bills require hospitals receiving additional slots to abide by specific conditions. At least 50 percent of the additional slots must be used for a shortage specialty residency program, defined as any approved residency program in a specialty identified by the Health Resources and Services Administration until the National Health Care Workforce Commission issues a report on specialty shortages. The hospitals must ensure that the total number of slots is not reduced prior to the increase, and the ratio of residents in a shortage specialty program cannot decrease prior to the increase.

Reimbursement Level for Additional Slots

Under both bills, new slots would be reimbursed at the hospital's otherwise applicable per resident amounts for DGME purposes and using the usual adjustment factor for IME reimbursement purposes.

Required Studies and Reports

Both bills would require the National Health Care Workforce Commission to submit a report to Congress by Jan. 1, 2018 on the physician workforce. The study would identify specialties for which there is a shortage. The bills also would require a study by the Government Accountability Office on strategies for increasing the diversity of the health professional workforce.