113TH CONGRESS
2D SESSION

S. 1978

To increase access to primary care services through training and accountability improvements.

IN THE SENATE OF THE UNITED STATES

JANUARY 30, 2014

Mr. UDALL of New Mexico introduced the following bill; which was read twice and referred to the Committee on Finance

---

A BILL

To increase access to primary care services through training and accountability improvements.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Increasing Primary Care Access Act of 2014''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Findings.
Sec. 3. Centers of Excellence in Primary Care.
Sec. 4. Medicare Indirect Medical Education (IME) performance adjustment and primary care training bonus.
Sec. 5. Increasing Medicare graduate medical education transparency.

Sec. 6. Ensuring appropriate representation of primary care physicians on groups making recommendations regarding relative values under the Medicare physician fee schedule.
Sec. 7. Primary care project.
Sec. 8. Regional centers for health workforce analysis.
Sec. 9. Payments for graduate medical education under the Medicaid program.
Sec. 10. National Center for Health Care Workforce Analysis.
Sec. 11. Teaching health center reauthorization.
Sec. 12. GAO studies on graduate medical education.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) A well prepared, effective primary care workforce can reduce health care costs and play a large role in the prevention and management of illness. A one-unit increase in primary care physicians per 10,000 population is associated with improved health outcomes such as all-cause, cancer, heart disease, and stroke mortality, as well as increased life expectancy.

(2) Primary care physicians include those trained in family medicine, general internal medicine, general pediatrics, and in some cases, gynecology. One primary care physician will generate 6 to 23 jobs in the community served by such physician, $900,000 to $1,200,000 in wages, salaries, and benefits, and nearly $100,000 in State and local taxes.

(3) As of 2011, only 32 percent of the physician workforce is comprised of primary care and only between 16 to 18 percent of graduates of allopathic

medical schools are likely to pursue a career in primary care.

(4) Primary care supply has a positive effect on the entire population, but the effect is greater in areas with higher income inequality and poverty, such as rural areas. Only about 10 percent of physicians in America practice in rural areas while 20 percent of the United States population is located in rural areas.

(5) Geographic areas with more general and family physicians per population have lower rates of mortality and hospitalization for conditions that should be preventable or detected early, such as diabetes, congestive heart failure, and hypertension.

(6) As of May 2011, there were 6,419 primary care health professional shortage areas, comprised of 66,300,000 individuals. It would take 17,636 practitioners to meet such individuals' need for primary care providers.

SEC. 3. CENTERS OF EXCELLENCE IN PRIMARY CARE.

Part C of title VII of the Public Health Service Act (42 U.S.C. 293k) is amended by adding at the end the following:

"Subpart III—Centers of Excellence in Primary Care

"SEC. 749C. CENTERS OF EXCELLENCE IN PRIMARY CARE.

''(a) IN GENERAL.—The Secretary shall make grants to, and enter into contracts with, schools of medicine and osteopathic medicine for the purpose of assisting the schools in supporting programs of excellence in primary care.

''(b) ELIGIBLE SCHOOLS.—To be eligible to receive a grant under subsection (a), a school of medicine or osteopathic medicine shall submit an application at such time, in such manner, and containing such information as the Secretary may require, including a description of innovative ideas that applicants propose to increase recruitment and retention in primary care, including pipeline, admissions, curriculum, mentoring, preparation for residency, and related purposes.

''(c) SELECTION OF RECIPIENTS.—

''(1) IN GENERAL.—The Secretary shall award a grant under this section to not less than 6 and not more than 10 eligible schools of medicine and osteopathic medicine. Such selected schools shall be designated as Centers of Excellence in Primary Care.

''(2) REQUIREMENTS RELATING TO RURAL AND UNDERSERVED AREAS.—Of the schools designated under paragraph (1)—

''(A) not less than 4 and not more than 7 shall be located in a rural area; and

''(B) not less than 2 and not more than 3 shall be located in a medically underserved area.

''(d) USE OF FUNDS.—A school of medicine or osteopathic medicine designated as a Center of Excellence under this section shall, in using funds provided under the grant, give funding priority to—

''(1) making medical school affordable for each admitted and graduated student, including through significant tuition scholarships, tuition remissions, and stipends, especially for low-income students, and other provisions, such as loan forgiveness for graduates who practice primary care for a specified duration of time;

''(2) conducting admissions processes that favor students who will work in rural and medically underserved areas, and consider factors such as rural birth, minority status or upbringing, and desire to serve rural and medically underserved populations;

''(3) developing curricula models and innovations that expedite medical school training, build needed skills for modern medical practice, and enhance affinity of graduates for practice in rural and

medically underserved areas (which may include 3-year undergraduate medical education models, rural and inner city rotations, and mentoring with rural physicians);

''(4) research whether students completing a service requirement in a rural or underserved area as part of the criteria for graduation improves access to care in such area;

''(5) implement tracking systems that—

''(A) assess practice patterns of medical school graduates and require annual reports on this information for the duration of the grant program; and

''(B) track all loan repayment and scholarship disbursements to assure that program goals are being met with regard to recipients serving in desired locations with expected populations of need for a minimum required amount of time; and

''(6) having interprofessional primary care health professions community-based service learning models for primary care residents, and include clerkships and continuity clinic experiences for medical, nurse practitioner, and physician assistant students interested in primary care.''.

SEC. 4. MEDICARE INDIRECT MEDICAL EDUCATION (IME) PERFORMANCE ADJUSTMENT AND PRIMARY CARE TRAINING BONUS.

(a) IN GENERAL.—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended—

(1) by redesignating the clause (x) as added by section 5505(b) of the Patient Protection and Affordable Care Act as clause (xi); and

(2) by adding at the end the following new clauses:

''(xii) ADJUSTMENT FOR PERFORMANCE.—

''(I) IN GENERAL.—The Secretary, in consultation with the advisory body under clause (xiii), shall establish and implement procedures under which the amount of payments that a hospital would otherwise receive for indirect medical education costs under this subparagraph for discharges occurring during an applicable period is adjusted based on the performance of the hospital on measures specified by the Secretary.

''(II) MEASURES.—The measures specified by the Secretary under this clause shall include measures on quality measurement and improvement, evidence-based medicine, interprofessional

teamwork, multidisciplinary teamwork, care coordination, and health information technology. Such measures shall include factors that promote training in primary care, such as—

''(aa) resident training in outpatient and community settings, including Federally qualified health centers, rural health clinics, teaching health centers, rural medical practices, facilities operated by the Veterans Administration, Indian Health Service facilities, including primary care training sites that are carried out through self determination contracts and are located in a rural or primary care health professional shortage area;

''(bb) salary and loan conditions for primary care residents;

''(cc) the percentage of all graduates practicing primary care 5 years after graduation;

''(dd) the percentage of all graduates practicing primary care in health professional shortage areas 5 years after graduation;

''(ee) the percentage of all primary care graduates from underrepresented minority groups, including African-Americans, Hispanic-Americans, and Native Americans, as well as other underserved populations;

''(ff) how the residency is responding to the workforce needs identified by State and regional centers for workforce analysis established under the National Center for Health Care Workforce Analysis or the National Health Care Workforce Commission;

''(gg) the provision of service to all socioeconomic levels of patients, including but not limited to Medicaid program populations;

''(hh) mentoring curriculum in primary care;

''(ii) systems-based practice, including training in new forms of delivery system models, such as care coordination, accountable care organizations, and patient-centered medical homes; and

"(jj) training in preventive care, chronic disease management, and population health and public health.

"(III) INITIAL MEASURE DEVELOPMENT TIMELINE.—

"(aa) PROPOSED SET OF MEASURES.—Not later than January 1, 2016, the Secretary shall publish in the Federal Register a proposed set of measures for use under this clause. The Secretary shall provide for a period of public comment on such measures.

"(bb) FINAL SET OF MEASURES.—Not later than June 30, 2016, the Secretary shall publish in the Federal Register the final set of measures to be specified by the Secretary for use under this clause.

"(IV) ADJUSTMENT.—Subject to subclause (V), the Secretary shall determine the amount of any adjustment under this clause to payments to a hospital under this subparagraph in an applicable period.

"(V) BUDGET-NEUTRAL WITH RESPECT TO PAYMENTS THAT WOULD OTHERWISE BE MADE.—In making adjustments under this

clause, the Secretary shall ensure that the total amount of payments made to all hospitals under this subparagraph for an applicable period is equal to the total amount of payments that would have been made to such hospitals under this subparagraph in such period if this clause had not been enacted.

''(VI) PRIMARY CARE DEFINED.—In this clause, the term 'primary care' means family medicine, general internal medicine, general pediatrics, preventive medicine, obstetrics and gynecology, psychiatry, and any other specialty which provides integrated, accessible health care services and is accountable for addressing a large majority of health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

''(VII) APPLICABLE PERIOD DEFINED.—In this clause, the term 'applicable period' means the 12-month period beginning on July 1 of each year (beginning with 2015).

''(xiii) USE OF ADVISORY BODY.—

''(I) IN GENERAL.—Subject to subclause (III), the Secretary shall establish an advisory group to advise the Secretary on the application

of clause (xii), including the development of the measures to be used, how data on the measures may be collected, which measures will be required in any given reporting period, the applicable thresholds for the measures, and the mechanisms to be used in order to determine whether a hospital has met a threshold.

''(II) MAKE-UP OF GROUP.—The advisory group established under subclause (I) shall include—

''(aa) representatives of accrediting and certifying organizations;

''(bb) representatives of facilities that receive payments under this subparagraph;

''(cc) representatives of specialty boards and primary care boards;

''(dd) representatives of high-performing health care systems;

''(ee) experts in family medicine, primary care, and preventive medicine;

''(ff) representatives of public and private purchasers;

''(gg) representatives of consumer and patient organizations, especially those from rural areas; and

"(hh) other entities and individuals as determined by the Secretary of Health and Human Services.

"(III) USE OF EXISTING ENTITY.—If the Secretary determines that an existing entity is comprised of the individuals described in subclause (II) and that such entity has the expertise to advise the Secretary on the matters described in subclause (I), the Secretary may enter into an arrangement with such entity to advise the Secretary on such matters rather than establishing a new advisory group under subclause (I).".

(b) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on the application of clause (xii) of section 1886(d)(5)(B) of the Social Security Act, as added by subsection (a), including an analysis of any changes in workforce patterns as a result of the application of such clause.

(2) REPORT.—Not later than January 1, 2018, the Comptroller General of the United States shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations for such legislation and administrative action

as the Comptroller General determines to be appropriate.

SEC. 5. INCREASING MEDICARE GRADUATE MEDICAL EDUCATION TRANSPARENCY.

(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 a report on the graduate medical education payments that hospitals and other facilities receive under the Medicare program. The report shall include the following information with respect to each hospital or facility that receives such payments:

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

(2) The indirect medical education payments made to the hospital or other facility under section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(1)(B)).

(3) The number of residents counted for purposes of making the payments described in paragraph (1).

(4) The number of residents counted for purposes of making the payments described in paragraph (2).

(5) The number of residents, if any, that are not counted for purposes of making payments described in paragraph (1).

(6) The number of residents, if any, that are not counted for purposes of making payments described in paragraph (2).

(7) The percent that the payments described in paragraphs (1) and (2) that are made to the hospital or other facility make up of the total costs that the hospital or other facility incurs in providing graduate medical education, including salaries, benefits, operational expenses, and all other patient care costs.

(8) The number of residents training in each specialty.

(9) A list that identifies any training partners and the sponsoring institutions for each residency program.

SEC. 6. ENSURING APPROPRIATE REPRESENTATION OF PRIMARY CARE PHYSICIANS ON GROUPS MAKING RECOMMENDATIONS REGARDING RELATIVE VALUES UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

Section 1848(c)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)(iii)) is amended by adding at the end the following new sentence: ''The Secretary may not consult with an organization representing physicians if the organization uses a group to formulate recommendations regarding adjustments under clause (i) unless at least 40 percent of the members of the group are physicians who are board certified and actively practicing in family medicine, general internal medicine, general pediatrics, preventive medicine, obstetrics and gynecology, or psychiatry.''.

SEC. 7. PRIMARY CARE PROJECT.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish a pilot program to provide funding for graduate medical residency training programs in primary care.

(b) APPLICATION AND SELECTION OF SITES.—

(1) IN GENERAL.—An entity shall be eligible to participate in the project under this section if such entity—

(A) is—

(i) a community-based corporate entity collaborating with 1 or more hospitals to operate a primary care residency program;

(ii) a medical education entity established by 1 or more hospitals to operate a primary care residency program;

(iii) a hospital subsidiary or independent corporation operating a primary care residency program;

(iv) a medical education entity, independent of a hospital, collaborating with a primary care residency program; or

(v) another type of entity as determined appropriate by the Secretary; and

(B) submits an application at such time, in such manner, and containing such information as the Secretary may require.

(2) SELECTION OF PARTICIPANTS.—The Secretary shall select, from the eligible entities under paragraph (1), 4 entities to participate in the project. Not less than 1 selected entity shall be an entity that is not a hospital.

(c) ACTIVITIES UNDER THE PROJECT.—In carrying out the project, the Secretary shall—

(1) structure the funding of the project such that payments are made directly to the entity participating in the project;

(2) support primary care training in all sites where care is delivered, including non-hospital settings such as Federally qualified health centers (as defined in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)));

(3)(A) increase funding for the primary care residency programs of the participating entities such that those primary care residency programs are funded at the 90th percentile of all residency programs nationally and are funded at levels that equal at least $100,000 per resident involved; and

(B) ensure that entities participating in the project use the funding under the project to provide infrastructure support and recruitment and retention support for faculty and residents of the primary care residency program, including loan repayment for such residents;

(4) require training in rural and medically underserved areas, and with medically underserved populations (as defined in section 330(b) of the Public Health Service Act (42 U.S.C. 254b(b))) and

service in such areas for a minimum of two rotations of not less than four weeks each year; and

(5) permit the primary care residency program of the participating entities to qualify for payment under section 1886(d)(5)(B)(xii) of the Social Security Act (as added by section 4) if such entities receive an appropriate score (as determined by the Secretary) on the measures specified by the Secretary under such section.

(d) TERM OF PROJECT.—The Secretary shall carry out the project under this section for a term of at least 6 years.

(e) EVALUATION.—

(1) IN GENERAL.—Not later than 1 year after the commencement of the project, and each year thereafter, the Secretary shall conduct an of evaluation the project.

(2) CONTENT.—The Secretary shall conduct the evaluation under paragraph (1) using the following criteria:

(A) The percentage of graduates from the primary care residency programs of the participating entities that are practicing primary care 2 years after graduation, and longer.

(B) The percentage of graduates from the primary care residency programs of the participating entities that are practicing in a health professional shortage area (as defined in section 332 of the Public Health Service Act (42 U.S.C. 254e)) 2 years after graduation, and longer.

(C) Other criteria as determined appropriate by the Secretary.

(f) AUTHORIZATION OF APPROPRIATION.—There are authorized to be appropriated to carry out this section $3,600,000 for each of fiscal years 2015 through 2019.

SEC. 8. REGIONAL CENTERS FOR HEALTH WORKFORCE ANALYSIS.

(a) IN GENERAL.—Section 761(c) of the Public Health Service Act (42 U.S.C. 294n(c)) is amended by adding at the end the following—

''(3) ESTABLISHMENT OF NEW CENTERS AND FUNDING TO PRIMARY CARE RESIDENCY PROGRAMS.—

''(A) ESTABLISHMENT OF NEW CENTERS.—

''(i) IN GENERAL.—Not later than 1 year after the date of enactment of the Increasing Primary Care Access Act of 2014,

the Secretary shall award grants to, or enter into contracts with, not less than 6 and not more than 8 additional eligible entities, as described in paragraph (1).

''(ii) REQUIREMENTS.—In awarding grants or entering into contracts under clause (i), the Secretary shall—

''(I) ensure that each Regional Center for Health Workforce Analysis established under this paragraph is located in the geographic region that the Center covers; and

''(II) seek to award such grants or enter into contracts with eligible entities that are multi-State consortia.

''(B) DISTRIBUTION OF FUNDING TO PRIMARY CARE RESIDENCY PROGRAMS.—

''(i) IN GENERAL.—Each Regional Center for Health Workforce Analysis established pursuant to a grant or contract under subparagraph (A) shall, from the funds described in subparagraph (D), allocate funding to primary care residency programs—

''(I) within the region served by the Regional Center for Health Workforce Analysis; and

''(II) that the Center has identified as a primary care residency program in need.

''(C) CONSULTATION.—Each Regional Center for Health Workforce Analysis established pursuant to a grant or contract under this subsection shall establish a consortium of academic institutions with which the Center shall consult in determining allocations under subparagraph (B).

''(D) FUNDING.—

''(i) AUTHORIZATION OF APPROPRIATIONS.—For each fiscal year, there is authorized to be appropriated to carry out this paragraph $4,000,000, of which not less than $500,000 shall be allocated to each Regional Center for Health Workforce Analysis established under this paragraph.

''(ii) USE OF FUNDS TO ESTABLISH NEW CENTERS.—Each entity receiving funds under this paragraph may use a por-

tion of such funding to establish the Regional Center for Health Workforce Analysis.''.

(b) CONFORMING AMENDMENT.—Section 761(e)(2) of the Public Health Service Act (42 U.S.C. 294n(e)(2)) is amended by striking ''subsection (c)'' and inserting ''paragraphs (1) and (2) of subsection (c)''.

SEC. 9. PAYMENTS FOR GRADUATE MEDICAL EDUCATION UNDER THE MEDICAID PROGRAM.

(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), is amended by adding at the end the following new subsection:

''(ee) INCREASED FMAP FOR TARGETED GRADUATE MEDICAL EDUCATION IN EXPANSION STATES.—

''(1) IN GENERAL.—The term 'medical assistance' includes payment for costs of graduate medical education consistent with this subsection, whether provided in or outside of a hospital.

''(2) INCREASED FMAP FOR EXPANSION STATES THAT EXPAND TARGETED GRADUATE MEDICAL EDUCATION.—Notwithstanding subsection (b), with respect to amounts expended by an Expansion State for medical assistance for targeted graduate medical education that is above the level of expenditures made by the Expansion State for such graduate

medical education for 2014, the Federal medical assistance percentage shall be equal to—

"(A) 100 percent for amounts expended in calendar quarters in 2015, 2016, or 2017;

"(B) 95 percent for amounts expended in calendar quarters in 2018;

"(C) 94 percent for amounts expended in calendar quarters in 2019;

"(D) 93 percent for amounts expended in calendar quarters in 2020; and

"(E) 90 percent for amounts expended in calendar quarters in 2021 or in each year thereafter.

"(3) DEFINITIONS.—In this subsection:

"(A) EXPANSION STATE.—The term 'Expansion State' means a State that elects in accordance with the amendments made by the Patient Protection and Affordable Care Act (Public Law 111–148) to this title to provide medical assistance to individuals described in subclause (VIII) of section 1902(a)(10)(A)(i).

"(B) TARGETED GRADUATE MEDICAL EDUCATION.—The term 'targeted graduate medical education' means graduate medical education for community-based, interprofessional primary

care residents and other health care students, located in a rural area or an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area, or for other workforce needs identified by State and regional centers for workforce analysis established under the National Center for Health Workforce Analysis.

''(C) PRIMARY CARE.—The term 'primary care' means family medicine, general internal medicine, general pediatrics, preventive medicine, obstetrics and gynecology, psychiatry, and any other specialty which provides integrated, accessible health care services and is accountable for addressing a large majority of health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2015. Nothing in this section shall be construed as affecting payments made before such date under a State plan under title XIX of the Social Security Act for graduate medical education.

SEC. 10. NATIONAL CENTER FOR HEALTH CARE WORKFORCE ANALYSIS.

Section 761(b)(2)(A) of the Public Health Service Act (42 U.S.C. 294n(b)(2)(A)) is amended by inserting before the semicolon, the following: ", including national and regional workforce issues related to spending under the Medicaid program under title XIX of the Social Security Act".

SEC. 11. TEACHING HEALTH CENTER REAUTHORIZATION.

(a) REAUTHORIZATION OF THE TEACHING HEALTH CENTERS PROGRAM.—Section 340H of the Public Health Service Act (42 U.S.C. 256h) is amended—

(1) in subsection (g)—

(A) by inserting before the period the following: ", and not to exceed $800,000,000, for the period of fiscal years 2016 through 2020"; and

(B) by adding at the end the following: "Any amounts appropriated under this subsection for any of fiscal years 2011 through 2020 and remaining unexpended at the end of the fiscal year involved may be used in subsequent fiscal years to carry out this section.";

(2) in subsection (h)(2)—

(A) in the paragraph heading, by adding at the end the following: ''; SUBMISSION TO CONGRESS''; and

(B) by adding at the end the following:

''(C) SUBMISSION TO CONGRESS.—The Secretary shall annually submit to Congress a report that contains a compilation of the data submitted to the Secretary under paragraph (1) for the year involved.'';

(3) by redesignating subsections (h) through (j) as subsections (i) through (k), respectively; and

(4) by inserting after subsection (g), the following:

''(h) LIMITATION.—The Secretary shall establish a minimum per resident per year payment amount for funding of all approved teaching health center graduate medical education positions under this section that shall be not less than the per resident per year payment amount as of January 1, 2013, and ensure that not less than such amount is provided to all teaching health center graduate medical education programs for all approved positions.''.

(b) TEACHING HEALTH CENTERS DEVELOPMENT GRANTS.—Section 749A(g) of the Public Health Service Act (42 U.S.C. 293l–1(g)) is amended by striking ''each

fiscal year thereafter'' and inserting ''each of fiscal years 2013 through 2020 and each fiscal year thereafter''.

SEC. 12. GAO STUDIES ON GRADUATE MEDICAL EDUCATION.

(a) STUDY.—The Comptroller General of the United States shall conduct a study on each of the following:

(1) The potential of making graduate medical education payments under the Medicare program for mid-level health providers (such as physician assistants and nurse practitioners) in order to allow physicians and other health care providers to perform to their full scope of practice.

(2) The actual costs involved in training residents in different residency specialty types.

(b) REPORT.—Not later than one year after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on each of the studies conducted under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines to be appropriate.

○