I

111TH CONGRESS
1ST SESSION

H. R. 3109

To improve access to health care services in rural, frontier, and urban underserved areas in the United States by addressing the supply of health professionals and the distribution of health professionals to areas of need.

IN THE HOUSE OF REPRESENTATIVES

JUNE 26, 2009

Mr. TEAGUE (for himself, Mr. GENE GREEN of Texas, Mr. SPACE, and Mr. GONZALEZ) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Veterans' Affairs, Education and Labor, Armed Services, and Natural Resources, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

---

A BILL

To improve access to health care services in rural, frontier, and urban underserved areas in the United States by addressing the supply of health professionals and the distribution of health professionals to areas of need.

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 ''Health Access and Health Professions Supply Act of 2009'' or ''HAHPSA 2009''.

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

SEC. 2. FINDINGS.

(a) FINDINGS RELATED TO HEALTH CARE ACCESS IN RURAL, FRONTIER, AND URBAN UNDERSERVED AREAS OF THE UNITED STATES.—Congress finds the following:

(1) The United States does not have a cohesive or coordinated approach to addressing health workforce shortages and problems with reliable access to quality, affordable health care.

(2) There are 50,000,000 citizens of the United States living in areas that are designated under section 332(a)(1)(A) of the Public Health Service Act as health professional shortage areas.

(3) The population of the United States will grow by 25,000,000 each decade.

(4) The number of individuals over 65 years of age in the United States will double between 2000 and 2030, with such individuals accounting for 20 percent of the total population of the United States in 2030.

(5) Individuals over 65 years of age have twice as many doctor visits as those individuals under 65

years of age, resulting in an increase in the demand for physicians, physician assistants, pharmacists behavioral and mental health professionals, nurses, and dentists.

(6) The rates of chronic diseases (such as diabetes) are increasing in the population of the United States.

(7) There are 47,000,000 citizens of the United States who do not have health insurance, and over 130,000,000 individuals within the United States who do not have dental insurance. Those individuals who are uninsured have limited access to health care.

(8) Academic health centers, Federal medical facilities, and teaching hospitals provide a substantial percentage of safety net services in the United States to uninsured and underinsured populations and to those individuals who have 1 or more chronic diseases. Such centers, facilities, and teaching hospitals provide those safety net services while concurrently providing for the training of health professionals.

(9) The pipeline for the education of health professionals—

(A) begins and often ends in urban areas;

(B) does not reliably include Federal support for nonphysician training;

(C) does not incorporate modern training venues and techniques, including community-based ambulatory sites; and

(D) discourages interdisciplinary, team, and care coordination models as a result of restrictive regulations.

(10) Health reform must include measures to transform the health delivery system to assure access, quality, and efficiency by utilizing contemporary models and venues of care.

(11) Reform of the health delivery system will require modernization of the training of health professionals to ensure that health professionals—

(A) practice in integrated teams in a variety of delivery venues (including inpatient and ambulatory settings and long-term care facilities) to utilize decision support and health information systems;

(B) deliver patient-centered care;

(C) practice evidence-based health care;

(D) learn performance-based compensation systems, comparative effectiveness, and costs of care across the spectrum; and

(E) deliver culturally appropriate, personalized care.

(b) FINDINGS RELATED TO ACCESS TO ORAL HEALTH.—Congress finds the following:

(1) Dental care is the number 1 unmet health care need in children, and is 1 of the top 5 unmet health care needs in adults.

(2) Over 130,000,000 citizens of the United States are without dental insurance.

(3) Over 45,000,000 citizens of the United States live in areas that are designated under section 332(a)(1)(A) of the Public Health Service Act as dental health professional shortage areas.

(4) Rural counties have less than half the number of dentists per capita compared to large metropolitan areas (29 versus 62 for population of 100,000).

(5) In 2006, over 9,000 dentists were needed in such dental health professional shortage areas.

(6) Between 27 and 29 percent of children and adults in the United States have untreated cavities.

(7) The number of dental school graduates in the United States decreased by 20 percent between 1982 and 2003 and the average age of practicing dentists in the United States is 49.

(8) There were over 400 dental faculty vacancies in the school year beginning in 2006.

(9) In 2007, the average debt of a dental student at graduation was $172,627.

(c) FINDINGS RELATED TO PHYSICIAN SHORTAGES, EDUCATION, AND DISTRIBUTION.—Congress finds the following:

(1) By 2020, physician shortages are forecasted to be in the range of 55,000 to 200,000.

(2) Although 21 percent of the population of the United States lives in rural areas, only 10 percent of physicians work in rural areas and, for every 1 physician who goes into practice in regions with a low supply of physicians, 4 physicians go into practice in regions with a high supply of physicians.

(3) According to a 2004 report by Green et al. for the Robert Graham Center of the American Academy of Family Physicians, the number of applicants from rural areas accepted to medical school has decreased by 40 percent in the last 20 years while the number of such applications has remained the same.

(4) In order to respond to forecasted shortages, experts have recommended an increase between 15

and 30 percent in class size at medical schools over the next 10 years.

(5) There are 55,000,000 citizens of the United States who lack adequate access to primary health care because of shortages of primary care providers in their communities.

(6) The number of graduates from medical school in the United States who choose to practice family medicine has plummeted 50 percent in less than 10 years. Without congressional intervention, such decline will likely continue, and access to care in underserved areas will rapidly deteriorate. Family physicians represent 58 percent of the rural physician workforce, 70 percent of non-Federal physicians in whole-county health professional shortage areas, and 78 percent of primary care physician full-time equivalents in the National Health Service Corps.

(7) Current trends indicate that fewer resident trainees from pediatric and internal medicine residencies pursue generalist practice at graduation.

(8) Funding for medical education which is provided through direct Graduate Medical Education (GME) and Indirect Medical Education (IME) under the Medicare program is not transparent or accountable, nor is it aligned to the types of health

professionals most needed or to the areas in which health professionals are most needed.

(9) Physician supply varies 200 percent across regions and there is no relationship between regional physician supply and health needs.

(10) The Council on Graduate Medical Education's 18th Report (issued in 2007), entitled ''New Paradigms for Physician Training for Improving Access to Health Care'', and 19th Report (issued in 2007), entitled ''Enhancing Flexibility in Graduate Medical Education'', each call for changes to address the healthcare needs of the United States by removing barriers to expanding and more appropriately training the physician workforce.

(d) FINDINGS RELATED TO NURSING SHORTAGES, EDUCATION, AND DISTRIBUTION.—Congress finds the following:

(1) By 2020, nursing shortages are forecast to be in the range of 300,000 to 1,000,000 and the Bureau of Labor Statistics of the Department of Labor estimates that more than 1,200,000 new and replacement registered nurses will be needed by 2014.

(2) Nurse vacancy rates are currently 8 percent or greater in hospitals and community health centers

receiving assistance under section 330 of the Public Health Service Act, and for nursing faculty positions.

(3) Surveys indicate that 40 percent of nurses in hospitals are dissatisfied with their work and, of nurses who graduate and go into nursing, 50 percent leave their first employer within 2 years.

(4) Nursing baccalaureate and graduate programs rejected more than 40,000 qualified nursing school applicants in 2006, with faculty shortages identified by such programs as a major reason for turning away qualified applicants.

(5) More than 70 percent of nursing schools cited faculty shortages as the primary reason for not accepting all qualified applicants into entry-level nursing programs.

(6) The nursing faculty workforce is aging and retiring and, by 2019, approximately 75 percent of the nursing faculty workforce is expected to retire.

(7) The average age of nurses in the United States is 49 and the average age of an associate professor nurse faculty member in the United States is 56.

(8) Geriatric patients receiving care from nurses trained in geriatrics are less frequently re-

admitted to hospitals or transferred from skilled nursing facilities and nursing facilities to hospitals.

(e) FINDINGS RELATED TO PUBLIC HEALTH WORKFORCE SHORTAGES.—Congress finds the following:

(1) The United States has an estimated 50,000 fewer public health workers than it did 20 years ago while the population has grown by approximately 22 percent.

(2) Government public health departments are facing significant workforce shortages that could be exacerbated through retirements.

(3) Twenty percent of the average State health agency's workforce will be eligible to retire within 3 years, and by 2012, over 50 percent of some State health agency workforces will be eligible to retire.

(4) Approximately 20 percent of local health department employees will be eligible for retirement by 2010.

(5) The average age of new hires in State health agencies is 40.

(6) Four out of 5 current public health workers have not had formal training for their specific job functions.

(f) FINDINGS RELATED TO PHYSICIAN ASSISTANT SHORTAGES.—Congress finds the following:

(1) The purpose of the physician assistant profession is to extend the ability of physicians to provide primary care services, particularly in rural and other medically underserved communities.

(2) Physician assistants always practice medicine as a team with their supervising physicians, however, supervising physicians need not be physically present when physician assistants provide medical care.

(3) Physician assistants are legally regulated in all States, the District of Columbia, and Guam. All States, the District of Columbia, and Guam authorize physicians to delegate prescriptive authority to physician assistants.

(4) In 2007, physician assistants made approximately 245,000,000 patient visits and prescribed or recommended approximately 303,000,000 medications.

(5) The National Association of Community Health Centers, the George Washington University, and the Robert Graham Center for Policy Studies in Family Medicine and Primary Care found that while the number of patients who seek care at community health centers has increased, the number of primary care providers, including physician assistants, has

not. The report estimates a need for 15,500 primary health care providers to provide care at community health centers.

(g) FINDINGS RELATED TO MENTAL HEALTH PROFESSIONAL SHORTAGES.—Congress finds the following:

(1) The National Institute of Mental Health estimates that 26.2 percent of citizens of the United States ages 18 and older suffer from a diagnosable mental disorder. Approximately 20 percent of children in the United States have diagnosable mental disorders with at least mild functional impairment.

(2) The Health Resources and Services Administration reports that there are 3,059 mental health professional shortage areas within the United States with 77,000,000 people living in those areas. More than 5,000 additional mental health professionals are needed to meet demand.

(3) According to the Department of Health and Human Services, minority representation is lacking in the mental health workforce. Although 12 percent of the population of the United States is African-American, only 2 percent of psychologists, 2 percent of psychiatrists, and 4 percent of social workers are African-American. Moreover, there are only 29 mental health professionals who are Hispanic for every

100,000 individuals who are Hispanic in the United States, compared with 173 non-Hispanic White providers for every 100,000 individuals who are non-Hispanic White in the United States.

(h) FINDINGS RELATED TO HEALTH PROFESSIONAL SHORTAGE AREAS.—

(1) In 2006, the National Health Service Corps had a total of 4,200 vacant positions in health professional shortage areas, but only 1,200 of those positions were funded. For each National Health Service Corps award, there are 7 applicants.

(2) Community health centers receiving assistance under section 330 of the Public Health Service Act have expanded to serve 16,000,000 individuals in over 1,000 sites. Such community health centers have high vacancy rates for family physicians (13 percent), obstetricians and gynecologists (21 percent), dentists, nurses, and other health professionals.

(3) The Institute of Medicine of the National Academies has recommended that medical education and public health issues be more closely aligned, especially in relation to preparedness for natural disasters, pandemic, bioterrorism, and other threats to public health.

(4) The education of health professionals must be more closely aligned with health care needs in the United States, with special attention to underserved populations and areas, health disparities, the aging population, and individuals with 1 or more chronic diseases.

(5) There is some duplication, and little coordination, between the Council on Graduate Medical Education (related to the physician workforce), the National Advisory Committee on Nursing Programs (related to the nursing workforce), the Advisory Committee on Training in Primary Care Medicine and Dentistry, and other advisory committees and councils.

(6) The Association of Academic Health Centers calls for making the health workforce of the United States a priority domestic policy issue and creating a national health workforce planning body that engages Federal, State, public, and private stakeholders.

TITLE I—AMENDMENTS TO THE SOCIAL SECURITY ACT

Subtitle A—Workforce Improvements

SEC. 101. NATIONAL HEALTH CARE WORKFORCE COMMISSION.

(a) PURPOSE.—It is the purpose of this section to establish a National Health Care Workforce Commission that—

(1) serves as a national resource for Congress, the President, States, and localities by—

(A) disseminating information on current and projected health care workforce supply and demand;

(B) disseminating information on health care workforce education and training capacity and instruction or delivery models and best practices;

(C) recognizing efforts of Federal, State, and local partnerships to develop and offer health care career pathways of proven effectiveness;

(D) disseminating information on promising retention practices for health care professionals;

(E) communicating information on important policies and practices that affect the recruitment, education and training, and retention of the health care workforce; and

(F) disseminating recommendations on the development of a fiscally sustainable integrated workforce that supports a high-quality health care delivery system that meets the needs of patients and populations;

(2) communicates and coordinates with the Departments of Health and Human Services, Labor, and Education on related activities administered by one or more of such Departments;

(3) develops and commissions evaluations of education and training activities to determine whether the demand for health care workers is being met;

(4) identifies barriers to improved coordination at the Federal, State, and local levels and recommend ways to address such barriers; and

(5) encourages innovations to address population needs, constant changes in technology, and other environmental factors.

(b) ESTABLISHMENT.—There is hereby established the National Health Care Workforce Commission (in this section referred to as the ''Commission'').

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members to be appointed by the Comptroller General.

(2) QUALIFICATIONS.—

(A) IN GENERAL.—The membership of the Commission shall include individuals—

(i) with national recognition for their expertise in health care labor market analysis, including health care workforce analysis; health care finance and economics; health care facility management; health care plans and integrated delivery systems; health care workforce education and training; health care philanthropy; providers of health care services; and other related fields; and

(ii) who will provide a combination of professional perspectives, broad geographic representation, and a balance between urban, suburban, and rural representatives.

(B) INCLUSION.—

(i) IN GENERAL.—The membership of the Commission shall include no less than one representative of—

(I) the health care workforce and health professionals;

(II) employers;

(III) third-party payers;

(IV) individuals skilled in the conduct and interpretation of health care services and health economics research;

(V) representatives of consumers;

(VI) labor unions;

(VII) State or local workforce investment boards; and

(VIII) educational institutions (which may include elementary and secondary institutions, institutions of higher education, including 2 and 4 year institutions, or registered apprenticeship programs).

(ii) ADDITIONAL MEMBERS.—The remaining membership may include additional representatives from clause (i) and other individuals as determined appro-

priate by the Comptroller General of the United States.

(C) MAJORITY NON-PROVIDERS.—Individuals who are directly involved in health professions education or practice shall not constitute a majority of the membership of the Commission.

(3) TERMS.—

(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that the Comptroller General shall designate staggered terms for the members first appointed.

(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that members term until a successor has taken office. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

(4) COMPENSATION.—While serving on the business of the Commission (including travel time), a member of the Commission shall be entitled to

compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of tile 5, United States Code, and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

(5) CHAIRMAN, VICE CHAIRMAN.—The members of the Commission shall elect, by a majority vote, a chairman and vice chairman of the Commission for the term of their appointment of portion remaining. Such elections shall occur at the end of any chair-

man or vice chairman's term or upon the resignation of the chairman or vice chairman from the Commission.

(6) MEETINGS.—The Commission shall meet at the call of the chairman, but no less frequently than on a quarterly basis.

(d) DUTIES.—

(1) REVIEW OF HEALTH CARE WORKFORCE AND ANNUAL REPORTS.—In order to develop a fiscally sustainable integrated workforce that supports a high-quality, readily accessible health care delivery system that meets the needs of patients and populations, the Commission, in consultation with relevant Federal, State, and local agencies, shall—

(A) review current and projected health care workforce supply and demand, including the topics described in paragraph (2);

(B) make recommendations to Congress and the Administration concerning national health care workforce priorities, goals, and policies;

(C) by not later than October 1 of each year (beginning with 2011), submit a report to Congress and the Administration containing the

results of such reviews and recommendations concerning related policies; and

(D) by not later than April 1 of each year (beginning with 2011), submit a report to Congress and the Administration containing a review of, and recommendations on, at a minimum one high priority area as described in paragraph (3).

(2) SPECIFIC TOPICS TO BE REVIEWED.—The topics described in this paragraph include—

(A) current health care workforce supply and distribution, including demographics, skill sets, and demands, with projected demands during the subsequent 10 and 25 year periods;

(B) health care workforce education and training capacity, including the number of students who have completed education and training, including registered apprenticeships; the number of qualified faculty; the education and training infrastructure; and the education and training demands, with projected demands during the subsequent 10 and 25 year periods, and including identified models of education and training delivery and best practices;

(C) the implications of new and existing Federal policies which affect the health care workforce, including Medicare and Medicaid graduate medical education policies, titles VII and VIII of the Public Health Service Act (42 U.S.C. 292 et seq. and 296 et seq.), the National Health Service Corps (with recommendations for aligning such programs with national health workforce priorities and goals), and other health care workforce programs, including those supported through the Workforce Investment Act of 1998 (29 U.S.C. 2801 et seq.), the Carl D. Perkins Career and Technical Education Act of 2006 (20 U.S.C. 2301 et seq.), the Higher Education Act of 1965 (20 U.S.C. 1001 et seq.), and any other Federal health care workforce programs; and

(D) the health care workforce needs of special populations, such as minorities, rural populations, medically underserved populations, gender specific needs, and geriatric and pediatric populations with recommendations for new and existing Federal policies to meet the needs of these special populations.

(3) HIGH PRIORITY AREAS.—

(A) IN GENERAL.—The initial high priority topics described in this paragraph include—

(i) integrated health care workforce planning that identifies health care professional skills needed and maximizes the skill sets of health care professionals across disciplines;

(ii) an analysis of the nature, scopes of practice, and demands for health care workers in the enhanced information technology and management workplace;

(iii) Medicare and Medicaid graduate medical education policies and recommendations for aligning with national workforce goals;

(iv) nursing workforce capacity at all levels, including education and training capacity, projected demands, and integration within the health care delivery system;

(v) oral health care workforce capacity, including education and training capacity, projected demands, and integration within the health care delivery system;

(vi) mental and behavioral health care workforce capacity, including education

and training capacity, projected demands, and integration within the health care delivery system;

(vii) allied health and public health care workforce capacity, including education and training capacity, projected demands, and integration within the health care delivery system; and

(viii) the geographic distribution of health care providers as compared to the identified health care workforce needs of States and regions.

(B) FUTURE DETERMINATIONS.—The Commission may require that additional topics be included under subparagraph (A). The appropriate committees of Congress may recommend to the Commission the inclusion of other topics for health care workforce development areas that require special attention.

(4) GRANT PROGRAM.—The Commission shall oversee and report to Congress on the State Health Care Workforce Development Grants program established in section 412.

(5) STUDY.—The Commission shall study effective mechanisms for financing education and train-

ing for careers in health care, including public health and allied health.

(6) RECOMMENDATIONS.—The Commission shall submit recommendations to Congress, the Department of Labor, and the Department of Health and Human Services about improving safety, health, and worker protections in the workplace for the health care workforce.

(7) ASSESSMENT.—The Commission shall assess and receive reports from the National Center for Health Care Workforce Analysis established under title VII of the Public Service Health Act.

(e) CONSULTATION WITH FEDERAL, STATE, AND LOCAL AGENCIES, CONGRESS, AND OTHER ORGANIZATIONS.—

(1) IN GENERAL.—The Commission shall consult with Federal agencies (including the Departments of Health and Human Services, Labor, Education, Commerce, Agriculture, Defense, and Veterans Affairs and the Environmental Protections Agency), Congress, the Medicare Payment Advisory Commission, and, to the extent practicable, with State and local agencies, voluntary health care organizations professional societies, and other relevant public-private health care partnerships.

(2) OBTAINING OFFICIAL DATA.—The Commission, consistent with established privacy rules, may secure directly from any department or agency of the United States information necessary to enable the Commission to carry out this section.

(3) DETAIL OF FEDERAL GOVERNMENT EMPLOYEES.—An employee of the Federal Government may be detailed to the Commission without reimbursement. The detail of such an employee shall be without interruption or loss of civil service status.

(f) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General of the United States determines to be necessary to ensure the efficient administration of the Commission, the Commission may—

(1) employ and fix the compensation of an executive director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

(4) make advance, progress, and other payments which relate to the work of the Commission;

(5) provide transportation and subsistence for persons serving without compensation; and

(6) prescribe such rules and regulations as the Commission determines to be necessary with respect to the internal organization and operation of the Commission.

(g) POWERS.—

(1) DATA COLLECTION.—In order to carry out its functions under this section, the Commission shall—

(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section, including coordination with the Bureau of Labor Statistics;

(B) carry out, or award grants or contracts for the carrying out of, original research

and development, where existing information is inadequate, and

(C) adopt procedures allowing interested parties to submit information for the Commission's use in making reports and recommendations.

(2) ACCESS OF THE GOVERNMENT ACCOUNTABILITY OFFICE TO INFORMATION.—The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and nonproprietary data of the Commission, immediately upon request.

(3) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by a third party appointed by the Secretary.

(h) AUTHORIZATION OF APPROPRIATIONS.—

(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General of the United States submits requests for appropriations. Amounts so appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

(3) GIFTS.—The Commission is authorized to accept and gifts for purposing of carrying out this section.

(i) DEFINITIONS.—In this section:

(1) HEALTH CARE WORKFORCE.—The term ''health care workforce'' includes all health care providers with direct patient care and support responsibilities, including physicians, nurses, physician assistants, pharmacists, oral healthcare professionals, allied health professionals, mental health professionals, and public health professionals.

(2) HEALTH PROFESSIONALS.—The term ''health professionals'' includes—

(A) dentists, dental hygienists, primary care providers, specialty physicians, nurses, nurse practitioners, physician assistants, psychologists and other behavioral and mental health professionals, social workers, physical therapists, public health professionals, clinical pharmacists, allied health professionals, chiropractors, community health workers, school nurses, certified nurse midwives, podiatrists, li-

censed complementary and alternative medicine providers, and integrative health practitioners;

(B) national representatives of health professionals;

(C) representatives of schools of medicine, osteopathy, nursing, allied health, educational programs for public health professionals, behavioral and mental health professionals (as so defined), social workers, physical therapists, oral health care industry dentistry and dental hygiene, and physician assistants;

(D) representatives of public and private teaching hospitals, and ambulatory health facilities, including Federal medical facilities; and

(E) any other health professional the Comptroller General of the United States determines appropriate.

SEC. 102. STATE HEALTH WORKFORCE CENTERS PROGRAM.

(a) ESTABLISHMENT.—The Secretary shall establish a demonstration program (in this section referred to as the ''program'') under which the Secretary makes grants to participating States for the operation of State Health Workforce Centers to carry out the activities described in subsection (c).

(b) PARTICIPATING STATES.—A State seeking to participate in the program shall submit an application to the Secretary containing such information and at such time as the Secretary may specify. The Secretary may only consider under the preceding sentence 1 application submitted by each State which has been certified by the Governor or the chief executive officer of the State.

(c) USE OF FUNDS.—Grants awarded under subsection (a) may be used to support activities designed to improve the training, deployment, and retention of critical health professionals in underserved areas and for underserved populations, including the following:

(1) Conducting assessments of key health professional capacity and needs. Such assessments shall be conducted in a coordinated manner that provides for the nationwide collection of health professional data.

(2) Convening State health professional policymakers to review education, education financing, regulations, and taxation and compensation policies which affect the training, deployment, and retention of health professionals. A participating State may, taking into consideration the results of such reviews, develop short-term and long-term recommendations for improving the supply, deployment, and retention

of critical health professionals in underserved areas and for underserved populations.

(d) FUNDING.—

(1) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $13,750,000 to carry out this section.

(2) MATCHING REQUIREMENT.—The Secretary may require a State, in order to be eligible to receive a grant under this section, to agree that, with respect to the costs incurred by the State in carrying out the activities for which the grant was awarded, the State will make available (directly or through donations from public or private entities) non-Federal contributions in an amount equal to a percent of Federal funds provided under the grant (as determined appropriate by the Secretary).

(e) DEFINITIONS.—In this section:

(1) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(2) STATE.—The term ''State'' means—

(A) a State;

(B) the District of Columbia;

(C) the Commonwealth of Puerto Rico; and

(D) any other territory or possession of the United States.

SEC. 103. IMPROVEMENTS TO PAYMENTS FOR GRADUATE MEDICAL EDUCATION UNDER MEDICARE.

(a) INCREASING THE MEDICARE CAPS ON GRADUATE MEDICAL EDUCATION POSITIONS.—

(1) DIRECT GRADUATE MEDICAL EDUCATION.—Section 1886(h)(4)(F) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(F)) is amended—

(A) in clause (i), by inserting ''clause (iii) and'' after ''subject to''; and

(B) by adding at the end the following new clause:

''(iii) INCREASE IN CAPS ON GRADUATE MEDICAL EDUCATION POSITIONS FOR STATES WITH A SHORTAGE OF RESIDENTS.—

''(I) IN GENERAL.—For cost reporting periods beginning on or after January 1, 2011, the Secretary shall increase the otherwise applicable limit on the total number of full-time equivalent residents in the field of allopathic or osteopathic medicine determined under clause (i) with respect

to a qualifying hospital by an amount equal to 15 percent of the amount of the otherwise applicable limit (determined without regard to this clause). Such increase shall be phased-in equally over a period of 3 cost reporting periods beginning with the first cost reporting period in which the increase is applied under the previous sentence to the hospital.

''(II) QUALIFYING HOSPITAL.—In this clause, the term 'qualifying hospital' means a hospital that agrees to use the increase in the number of full-time equivalent residents under subclause (I) to support community-based training which emphasizes underserved areas and innovative training models which address community needs and reflect emerging, evolving, and contemporary models of health care delivery. A qualifying hospital shall give priority to providing such training and training models to health professionals in specialties which the

Secretary, in consultation with the Permanent National Health Workforce Commission established under section 101(a) of the Health Access and Health Professions Supply Act of 2009, determines are in high-need (including family medicine, general surgery, geriatrics, general internal medicine, general surgery, and obstetrics and gynecology).

''(III) INCREASE IN PAYMENTS.—Notwithstanding any other provision of law, in the case of full-time equivalent residents added to a hospital's training program as a result of such increase, the Secretary shall provide for an increase in the amounts otherwise payable under this subsection with respect to direct graduate medical education costs that would otherwise apply with respect to such residents by 10 percent. Such increased payments shall be made to the facility in which the training is provided to such residents.''.

(2) INDIRECT MEDICAL EDUCATION.—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following new clause:

''(x) Clause (iii) of subsection (h)(4)(F) shall apply to clause (v) in the same manner and for the same period as such clause (iii) applies to clause (i) of such subsection.''.

(b) APPLICATION OF MEDICARE GME PAYMENTS TO ADDITIONAL TRAINING SITE VENUES.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall, by regulation, provide for the use of payments for direct graduate medical education costs under section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) and payments for the indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) to support the implementation of community-based training and innovative training models under subsections (h)(4)(F)(iii)(II) and (d)(5)(B)(x) of section 1886 of the Social Security Act (42 U.S.C. 1395ww).

(2) USE OF MODEL OF CARE DELIVERY.—In promulgating regulations under paragraph (1), the

Secretary shall consider the model of care delivery of the Institute of Medicine of the National Academies.

(3) CONSULTATION.—In promulgating such regulations, the Secretary shall consult with the Permanent National Health Workforce Commission established under section 101(a).

(c) DETERMINATION OF HOSPITAL-SPECIFIC APPROVED FTE RESIDENT AMOUNTS.—Section 1886(h)(2) of the Social Security Act (42 U.S.C. 1395ww(h)(2)) is amended by adding at the end the following new subparagraph:

"(G) FLEXIBILITY IN DETERMINATION.—

"(i) IN GENERAL.—Notwithstanding the preceding provisions of this paragraph, the approved FTE resident amount for each cost reporting period beginning on or after January 1, 2011, with respect to an applicable resident shall be determined using a methodology established by the Secretary that allows flexibility for payments to be made for costs in addition to the costs of hospital-sponsored education. Such methodology shall provide that non-teaching hospital-based entities (such as managed care organizations and public and

private healthcare consortia) that are capable of assembling all of the resources necessary for effectively providing graduate medical education may receive payments for providing graduate medical education, either as the sponsor of such graduate medical education program or as an affiliate of such a sponsor.

''(ii) APPLICABLE RESIDENT.—In this subparagraph, the term 'applicable resident' means a resident—

''(I) in a specialty which the Secretary, in consultation with the Permanent National Health Workforce Commission established under section 101(a) of the Health Access and Health Professions Supply Act of 2009, determines is in high-need;

''(II) in a health professional shortage area (as defined in section 332 of the Public Health Service Act);

''(III) in a medically underserved community (as defined in section 799B of the Public Health Service Act), or with respect to a medically

underserved population (as defined in section 330(b)(3) of the Public Health Service Act); and

''(IV) in a Federal medical facility.

''(iii) FEDERAL MEDICAL FACILITY.—In this subparagraph, the term 'Federal medical facility' means a facility for the delivery of health services, and includes—

''(I) a community health center (as defined in section 330 of the Public Health Service Act), a public health center, an outpatient medical facility, or a community mental health center;

''(II) a hospital, State mental hospital, facility for long-term care, or rehabilitation facility;

''(III) a migrant health center or an Indian Health Service facility;

''(IV) a facility for the delivery of health services to inmates in a penal or correctional institution (under section 323 of such Act) or a State correctional institution;

"(V) a Public Health Service medical facility (used in connection with the delivery of health services under section 320, 321, 322, 324, 325, or 326 of such Act); or

"(VI) any other Federal medical facility.".

SEC. 104. DISTRIBUTION OF RESIDENT TRAINEES IN AN EMERGENCY.

(a) EXCLUSION FROM 3-YEAR ROLLING AVERAGE.—Notwithstanding any other provision of law, in the case of a host hospital participating in an emergency Medicare GME affiliation agreement on or after the date of enactment of this Act and training residents in excess of its cap, consistent with the rolling average provisions applicable for closed programs as specified in section 413.79(d)(6) of title 42, Code of Federal Regulations, the Secretary of Health and Human Services shall exclude from the 3-year rolling average FTE residents associated with displaced residents during the period in which such agreement is in effect.

(b) ASSESSMENT AND REVISION OF GME POLICIES.—

(1) REVIEW.—The Secretary of Health and Human Services shall review policies with respect to

payments for direct graduate medical education costs under section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) and payments for the indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)).

(2) REVISION AND REPORT.—Not later than January 1, 2011, the Secretary shall—

(A) as appropriate, revise such policies that constrain the ability of the Secretary to respond to emergency situations and situations involving institutional and program closure; and

(B) in the case where the Secretary determines legislative action is necessary to make such revisions, submit to Congress a report containing recommendations for such legislative action.

SEC. 105. AUTHORITY TO INCLUDE COSTS OF TRAINING OF PSYCHOLOGISTS IN PAYMENTS TO HOSPITALS FOR APPROVED EDUCATIONAL ACTIVITIES UNDER MEDICARE.

Effective for cost reporting periods beginning on or after the date that is 18 months after the date of enactment of this Act, for purposes of payment to hospitals under the Medicare program under title XVIII of the So-

cial Security Act for costs of approved educational activities (as defined in section 413.85 of title 42, Code of Federal Regulations), such approved educational activities shall include a 1-year doctoral clinical internship operated by the hospital as part of a clinical psychology training program that is provided upon completion of university course work.

Subtitle B—Geriatric Assessments and Chronic Care Management and Coordination Services Under the Medicare Program

SEC. 111. MEDICARE COVERAGE OF GERIATRIC ASSESSMENTS.

(a) COVERAGE OF GERIATRIC ASSESSMENTS.—

(1) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (DD), by striking ''and'' at the end;

(B) in subparagraph (EE), by adding ''and'' at the end; and

(C) by adding at the end the following new subparagraph:

''(FF) geriatric assessments (as defined in subsection (hhh)(1));''.

(2) CONFORMING AMENDMENTS.—Clauses (i) and (ii) of section 1861(s)(2)(K) of the Social Security Act (42 U.S.C. 1395x(s)(2)(K)) are each amended by striking ''subsection (ww)(1)'' and inserting ''subsections (ww)(1) and (hhh)(1)''.

(b) GERIATRIC ASSESSMENTS DEFINED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsections:

''Geriatric Assessment

''(hhh)(1) The term 'geriatric assessment' means each of the following:

''(A) An assessment of the clinical status, functional status, social and environmental functioning, and need for caregiving of a geriatric assessment eligible individual (as defined in subsection (iii)). The assessment shall include a comprehensive history and physical examination and assessments of the following domains using standardized validated clinical tools:

''(i) Comprehensive review of medications and the individual's adherence to the medication regimen.

''(ii) Measurement of affect, cognition and executive function, mobility, balance, gait, risk of falling, and sensory function.

''(iii) Social functioning, environmental needs, and caregiver resources and needs.

''(iv) Any other domain determined appropriate by the Secretary.

''(B) The development of a written care plan based on the results of the assessment under subparagraph (A) (and any subsequent assessment under subparagraph (B)). The care plan shall detail identified problems, outline therapies, assign responsibility for actions, and indicate whether the individual is likely to benefit from chronic care management and coordination services (as defined in subsection (jjj)(1)). If the individual is determined likely to benefit from chronic care management and coordination services, the care plan shall also provide the basis for the chronic care management and coordination plan to be developed by the chronic care manager pursuant to subsection (jjj).

''(2) A geriatric assessment may only be conducted by—

''(A) a physician;

''(B) a practitioner described in section 1842(b)(18)(C)(i) under the supervision of a physician; or

''(C) any other provider that meets such conditions as the Secretary may specify.

''(3) An individual described in subclause (A), (B), or, if applicable, (C) may provide for the furnishing of services included in the geriatric assessment by other qualified health care professionals.

''(4)(A) Subject to subparagraph (B), a geriatric assessment of a geriatric assessment eligible individual may not be conducted more frequently than annually.

''(B) A geriatric assessment of a geriatric assessment eligible individual may be conducted more frequently than annually if the assessment is medically necessary due to a significant change in the condition of the individual.

''Geriatric Assessment Eligible Individual

''(iii)(1) Subject to paragraph (3), the term 'geriatric assessment eligible individual' means an individual identified by the Secretary as eligible for a geriatric assessment.

''(2) In identifying individuals under paragraph (1), the following rules shall apply:

''(A) The individual must have at least 1 of the following present:

''(i) Multiple chronic conditions that the Secretary identifies as likely to result in high expenditures under this title. In identifying such conditions, the Secretary may consider—

''(I) the hierarchal condition category methodology employed for risk adjustment under part C or other comparable methodologies the Secretary deems appropriate;

''(II) data from the Chronic Condition Data Warehouse under section 723 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003; and

''(III) indicators of geriatric syndromes, such as experiencing 2 or more falls in the past year, urinary incontinence, clinically significant depression, or other such indicators that the Secretary indicates as likely to result in high expenditures under this title when they exist in combination with one or more chronic conditions).

''(ii) Dementia, as defined in the most recent Diagnostic and Statistical Manual of Mental Disorders, and at least 1 other chronic condition.

''(iii) Any other factor identified by the Secretary.

''(B) The Secretary shall consult with physicians, physician groups and organizations, other health care professional groups and organizations, organizations representing individuals with chronic conditions and older adults, and other stakeholders in identifying conditions under clauses (i) and (ii) of subparagraph (A) and any factors under subparagraph (A)(iii).

''(3) The term 'geriatric assessment eligible individual' shall not include the following individuals:

''(A) An individual who is receiving hospice care under this title.

''(B) An individual who is residing in a skilled nursing facility, a nursing facility (as defined in section 1919), or any other facility identified by the Secretary.

''(C) An individual medically determined to have end-stage renal disease.

''(D) An individual enrolled in a Medicare Advantage plan or a plan under section 1876.

''(E) An individual enrolled in a PACE program under section 1894.

''(F) Any other categories of individuals determined appropriate by the Secretary.

''(4) For purposes of this subsection, the term 'chronic condition' means a condition, such as dementia, that lasts or is expected to last 1 year or longer, limits what an individual can do, and requires ongoing care.''.

(c) PAYMENT AND ELIMINATION OF COST-SHARING.—

(1) PAYMENT AND ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(A) in subparagraph (N), by inserting ''other than geriatric assessments (as defined in section 1861(hhh)(1))'' after ''(as defined in section 1848(j)(3))'';

(B) by striking ''and'' before ''(W)''; and

(C) by inserting before the semicolon at the end the following: '', and (X) with respect to geriatric assessments (as defined in section 1861(hhh)(1)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under section 1848(o)''.

(2) PAYMENT.—

(A) IN GENERAL.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended by adding at the end the following new subsection:

"(p) PAYMENT FOR GERIATRIC ASSESSMENTS.—

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—The Secretary shall establish—

"(i) a payment code (or codes) under this section for a geriatric assessment (as defined in section 1861(hhh)(1)) furnished to a geriatric assessment eligible individual (as defined in section 1861(iii)) by a physician, practitioner, or other provider described in section 1861(hhh)(2); and

"(ii) a payment amount for each such code.

"(B) REQUIREMENTS.—In establishing payment amounts under subparagraph (A)(ii), the Secretary shall—

"(i) take into account—

"(I) the amount of work required to perform a geriatric assessment, including the time and effort put forth by each qualified health care profes-

sional involved in performing the geriatric assessment; and

''(II) all of the costs associated with the geriatric assessment, including labor, supplies, equipment, and the costs of health information technologies and systems incurred by the physician, practitioner, or other provider (as described in section 1861(hhh)(2)) in providing the assessment; and

''(ii) ensure that such payments do not result in a reduction in payments for office visits or other evaluation and management services that would otherwise be allowable.

''(2) SEPARATE PAYMENTS FROM PAYMENTS FOR CHRONIC CARE MANAGEMENT AND COORDINATION SERVICES.—Payments for geriatric assessments shall be made separately from payments for chronic care management and coordination services (as defined in section 1861(jjj)(1)) and other services for which payment is made under this title.''.

(B) CONFORMING AMENDMENT.—Section 1848(j)(3) of the Social Security Act (42

U.S.C. 1395w–4(j)(3)), as amended by section 111(c)(2)), is amended by inserting ''(2)(FF),'' after ''(2)(EE),''.

(3) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—

(A) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by striking ''and diagnostic mammography'' and inserting '', diagnostic mammography, or geriatric assessments (as defined in section 1861(hhh)(1))''.

(B) CONFORMING AMENDMENTS.—Section 1833(a)(2) of the Social Security Act (42 U.S.C. 1395l(a)(2)) is amended—

(i) in subparagraph (F), by striking ''and'' at the end;

(ii) in subparagraph (G)(ii), by striking the comma at the end and inserting ''; and''; and

(iii) by inserting after subparagraph (G)(ii) the following new subparagraph:

''(H) with respect to geriatric assessments (as defined in section 1861(hhh)(1)) furnished

by an outpatient department of a hospital, the amount determined under paragraph (1)(X),''.

(4) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended—

(A) by striking ''and'' before ''(9)''; and

(B) by inserting before the period the following: '', and (10) such deductible shall not apply with respect to geriatric assessments (as defined in section 1861(hhh)(1))''.

(d) FREQUENCY LIMITATION.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)(1)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (N), by striking ''and'' at the end;

(B) in subparagraph (O) by striking the semicolon at the end and inserting '', and''; and

(C) by adding at the end the following new subparagraph:

''(P) in the case of geriatric assessments (as defined in section 1861(hhh)(1)), which are performed more frequently than is covered under such section;''; and

(2) in paragraph (7), by striking ''or (K)'' and inserting ''(K), or (P)''.

(e) EXCEPTION TO LIMITS ON PHYSICIAN REFERRALS.—Section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)) is amended by adding at the end the following new paragraph:

''(6) GERIATRIC ASSESSMENTS.—In the case of a designated health service, if the designated health service is a geriatric assessment (as defined in section 1861(hhh)(1)) and furnished by a physician.''.

(f) RULEMAKING.—The Secretary of Health and Human Services shall define such terms, establish such procedures, and promulgate such regulations as the Secretary determines necessary to implement the amendments made by, and the provisions of, this section, including the establishment of additional domains under subsection (hhh)(1)(A)(iv) of section 1861 of the Social Security Act, as added by subsection (b). In promulgating such regulations, the Secretary shall consult with physicians, physician groups and organizations, other health care professional groups and organizations representing individuals with chronic conditions and older adults.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to assessments furnished on or after January 1, 2010.

SEC. 112. MEDICARE COVERAGE OF CHRONIC CARE MANAGEMENT AND COORDINATION SERVICES.

(a) PART B COVERAGE OF CHRONIC CARE MANAGEMENT AND COORDINATION SERVICES.—

(1) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by section 111(a)(1), is amended—

(A) in subparagraph (EE), by striking ''and'' at the end;

(B) in subparagraph (FF), by adding ''and'' at the end; and

(C) by adding at the end the following new subparagraph:

''(GG) chronic care management and coordination services (as defined in subsection (jjj));''.

(2) CONFORMING AMENDMENTS.—(A) Clauses (i) and (ii) of section 1861(s)(2)(K) of the Social Security Act (42 U.S.C. 1395x(s)(2)(K)), as amended by section 111(a)(2), are each amended by striking ''subsections (ww)(1) and (hhh)(1)'' and inserting ''subsections (ww)(1), (hhh)(1), and (jjj)(1)''.

(B) Section 1862(a)(7) of the Social Security Act (42 U.S.C. 1395y(a)(7)), as amended by section 111(d), is amended by striking ''section 1861(s)(10)'' and inserting ''paragraphs (2)(GG) and (10) of section 1861(s)''.

(b) SERVICES DESCRIBED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 111(b), is amended by adding at the end the following new subsection:

''Chronic Care Management and Coordination Services; Chronic Care Manager; Chronic Care Eligible Individual

''(jjj)(1) The term 'chronic care management and coordination services' means services that are furnished to a chronic care eligible individual (as defined in paragraph (3)) by, or under the supervision of, a single chronic care manager (as defined in paragraph (2)) chosen by the chronic care eligible individual, a caregiver designated by the individual in writing, or a representative authorized to make decisions on the individual's behalf, under a plan of care prescribed by such chronic care manager for the purpose of chronic care coordination, including dementia as appropriate, which may include any of the following services:

''(A) The development of an initial plan of care (based on the results of a geriatric assessment, as defined in subsection (hhh)), and subsequent appropriate revisions to that plan of care.

''(B) The management of, and referral for, medical and other health services, including inter-

disciplinary care conferences and management with other providers.

''(C) The monitoring and management of medications.

''(D) Patient education and counseling services.

''(E) Family caregiver education and counseling services, including preventive care consistent with the patient's condition.

''(F) Self-management services, including health education and risk appraisal to identify behavioral risk factors through self-assessment.

''(G) Providing access for individuals, and caregivers or authorized representatives as appropriate, by telephone and e-mail to physicians or other appropriate health care professionals, including 24-hour availability of such professionals for after hours consultation.

''(H) Coordination with the principal nonprofessional caregiver in the home.

''(I) Managing and facilitating transitions that occur among health care professionals and across settings of care, including the following:

''(i) Pursuing the treatment option elected by the individual.

''(ii) Including any advance directive executed by the individual in the medical file of the individual.

''(J) Information about pain management and palliative care.

''(K) Information about, and referral to, hospice care, including patient and family caregiver education and counseling about hospice care, and facilitating transition to hospice care when elected.

''(L) Information about, referral to, and coordination with, community resources.

''(M) Such additional services for which payment would not otherwise be made under this title that the Secretary may specify that encourage the receipt of, or improve the effectiveness of, the services described in the preceding subparagraphs.

''(2)(A) For purposes of this subsection, the term 'chronic care manager' means an individual or entity that—

''(i) is—

''(I) a physician;

''(II) a practitioner described in clause (i) or (iv) of section 1842(b)(18)(C); or

''(III) any other provider that meets such conditions as the Secretary may specify;

''(ii) has entered into a chronic care management and coordination agreement with the Secretary; and

''(iii) is working in collaboration with, or under the supervision of, as determined by the Secretary—

''(I) the physician, practitioner, or other provider who completed the geriatric assessment of the individual; or

''(II) a physician, practitioner, or other provider to whom the individual's care was transferred by the physician, practitioner, or other provider who performed the geriatric assessment.

''(B)(i) For purposes of subparagraph (A)(ii), each chronic care management and coordination agreement shall meet the requirements described in subparagraph (C) and shall—

''(I) subject to clause (ii), be entered into for a period of 3 years and may be renewed if the Secretary is satisfied that the chronic care manager continues to meet such terms and conditions as the Secretary may require; and

''(II) contain such other terms and conditions as the Secretary may require.

''(ii) Each chronic care management and coordination agreement shall provide for the termination of such agreement prior to such 3-year period in the case where the chronic care manager—

''(I) is no longer able to provide chronic care services; or

''(II) does not meet such terms and conditions as the Secretary may require.

''(C)(i) Subject to clause (ii), the requirements of this subparagraph are met if the agreement requires the chronic care manager to perform, or provide for the performance of, the following services:

''(I) Advocating for, and providing ongoing support, oversight, and guidance with respect to the implementation of a plan of care that provides an integrated, coherent, and cross-disciplined plan for ongoing medical care that is developed in partnership with the chronic care eligible individual and all other physicians and other care providers and agencies (including home health agencies) providing care to the chronic care eligible individual.

''(II) Using evidence-based medicine and clinical decision support tools to guide decisionmaking at the point of care and on the basis of specific patient factors.

''(III) Using health information technology, including, where appropriate, remote monitoring and patient registries, to monitor and track the health status of patients and to provide patients with enhanced and convenient access to health care services.

''(IV) Encouraging patients to engage in the management of their own health through education and support systems.

''(V) Incorporating family caregivers into the chronic care planning process.

''(ii) The Secretary may modify the services required under the agreement under clause (i), including by requiring different services or services in addition to those described in subclauses (I) through (V) of such clause.

''(D) The Secretary shall adopt procedures which exempt providers in rural areas from providing 1 or more of the services otherwise required to be provided under subparagraph (C) or modify such requirements for such providers. In establishing such procedures, the Secretary shall ensure that such exemptions and modifications do not impact the quality of chronic care management and coordination services furnished by such providers.

''(3) For purposes of this subsection, the term 'chronic care eligible individual' means a geriatric assessment eligible individual (as defined in subsection (iii)) who has

undergone a geriatric assessment (as defined in subsection (hhh)(1)) which determined that the individual would benefit from chronic care management and coordination.

''(4) Chronic care management and coordination services may be furnished in the chronic care eligible individual's home or residence.''.

(c) PAYMENT AND ELIMINATION OF COST-SHARING.—

(1) PAYMENT AND ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by section 111(c)(1), is amended—

(A) in subparagraph (N), by inserting ''or chronic care management and coordination services (as defined in section 1861(jjj)(1))'' after ''other than geriatric assessments (as defined in section 1861(hhh)(1))'';

(B) by striking ''and'' before ''(X)''; and

(C) by inserting before the semicolon at the end the following: '', and (Y) with respect to chronic care management and coordination services (as defined in section 1861(jjj)(1)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under section 1848(p)''.

(2) PAYMENT.—

(A) IN GENERAL.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as amended by section 111(c)(2), is amended by adding at the end the following new subsection:

"(q) PAYMENT FOR CHRONIC CARE MANAGEMENT AND COORDINATION SERVICES.—

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—The Secretary shall establish—

"(i) a payment code (or codes) under this section for chronic care management and coordination services (as defined in paragraph (1) of section 1861(jjj)) furnished to a chronic care eligible individual (as defined in paragraph (3) of such section) by a chronic care manager (as defined in paragraph (2) of such section); and

"(ii) a payment amount for each such code.

"(B) REQUIREMENTS.—In establishing payment amounts under subparagraph (A)(ii), the Secretary shall—

"(i) take into account—

''(I) the amount of work required of the chronic care manager in providing chronic care management and coordination services to eligible individuals; and

''(II) all of the costs associated with providing chronic care management and coordination services, including labor, supplies, equipment, and the costs of health information technologies and systems incurred by the chronic care manager in providing such services;

''(ii) ensure that such payments are for such services furnished during a 30-day period; and

''(iii) ensure that such payments do not result in a reduction in payments for office visits or other evaluation and management services that would otherwise be allowable.

''(2) SEPARATE PAYMENTS FROM PAYMENTS FOR GERIATRIC ASSESSMENTS.—Payments for chronic care management and coordination services shall be made separately from payments for geriatric

assessments (as defined in section 1861(hhh)(1)) and other services for which payment is made under this title.''.

(B) CONFORMING AMENDMENT.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)), as amended by section 111(c)(2)), is amended by inserting ''(2)(GG),'' after ''(2)(FF),''.

(3) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—

(A) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)), as amended by section 111(c)(3)(A), is amended by striking ''or geriatric assessments (as defined in section 1861(hhh)(1))'' and inserting ''geriatric assessments (as defined in section 1861(hhh)(1)), or chronic care management and coordination services (as defined in section 1861(jjj)(1))''.

(B) CONFORMING AMENDMENTS.—Section 1833(a)(2) of the Social Security Act (42 U.S.C. 1395l(a)(2)), as amended by section 111(c)(3)(B), is amended—

(i) in subparagraph (G)(ii), by striking ''and'' at the end;

(ii) in subparagraph (H), by striking the comma at the end and inserting ''; and''; and

(iii) by inserting after subparagraph (H) the following new subparagraph:

''(I) with respect to chronic care management and coordination services (as defined in section 1861(jjj)(1)) furnished by an outpatient department of a hospital, the amount determined under paragraph (1)(Y),''.

(4) ELIMINATION OF DEDUCTIBLE.—Paragraph (10) of section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)), as added by section 111(c)(4), is amended by inserting ''or chronic care management and coordination services (as defined in section 1861(jjj)(1))'' after ''geriatric assessments (as defined in section 1861(hhh)(1))''.

(d) EXCEPTION TO LIMITS ON PHYSICIAN REFERRALS.—Section 1877(b)(6) of the Social Security Act (42 U.S.C. 1395nn(b)(6)), as amended by section 111(e), is amended to read as follows:

''(6) GERIATRIC ASSESSMENTS AND CHRONIC CARE MANAGEMENT AND COORDINATION SERV-

ICES.—In the case of a designated health service, if the designated health service is—

"(A) a geriatric assessment or a chronic care management and coordination service (as defined in subsections (hhh)(1) or (jjj)(1) of section 1861, respectively); and

"(B) furnished by a physician.".

(e) RULEMAKING.—The Secretary of Health and Human Services shall define such terms, establish such procedures, and promulgate such regulations as the Secretary determines necessary to implement the amendments made by, and the provisions of, this section. In promulgating such regulations, the Secretary shall consult with physicians, physician groups and organizations, other health care professional groups and organizations, and organizations representing individuals with chronic conditions and older adults.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to chronic care management and coordination services furnished on or after January 1, 2010.

SEC. 113. OUTREACH ACTIVITIES REGARDING GERIATRIC ASSESSMENTS AND CHRONIC CARE MANAGEMENT AND COORDINATION SERVICES UNDER THE MEDICARE PROGRAM.

The Secretary of Health and Human Services shall conduct outreach activities to individuals likely to be eligible to receive coverage of geriatric assessments (as defined in subsection (hhh)(1) of section 1861 of the Social Security Act, as added by section 111) under the Medicare program and individuals likely to be eligible to receive coverage of chronic care management and coordination services (as defined in subsection (jjj)(1) of such section 1861, as added by section 112) under the Medicare program, to inform such individuals about the availability of such benefits under the Medicare program.

SEC. 114. UTILIZATION OF TELEHEALTH SERVICES TO FURNISH GERIATRIC ASSESSMENTS AND CHRONIC CARE MANAGEMENT AND COORDINATION SERVICES UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1834(m)(4)(F) of the Social Security Act (42 U.S.C. 1395m(m)(4)(F)) is amended by adding at the end the following new clause:

"(iii) GERIATRIC ASSESSMENTS AND CHRONIC CARE MANAGEMENT AND COORDINATION SERVICES.—The term 'telehealth service' shall also include geriatric

assessments (as defined in section 1861(hhh)(1)) and chronic care management and coordination services (as defined in section 1861(jjj)).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2010.

SEC. 115. STUDY AND REPORT ON GERIATRIC ASSESSMENTS AND CHRONIC CARE MANAGEMENT AND COORDINATION SERVICES UNDER THE MEDICARE PROGRAM.

(a) STUDY.—The Secretary of Health and Human Services shall enter into a contract with an entity to conduct a study on—

(1) the effectiveness of the coverage of geriatric assessments and chronic care management and coordination services, including an evaluation of the use of interdisciplinary teams in providing such services, under the Medicare program (under the amendments made by sections 3 and 4) on improving the quality of care provided to Medicare beneficiaries with chronic conditions, including dementia; and

(2) the impact of such geriatric assessments and care coordination services on reducing expenditures under title XVIII of the Social Security Act,

including reduced expenditures that may result from—

(A) reducing preventable hospital admissions;

(B) more appropriate use of pharmaceuticals; and

(C) reducing duplicate or unnecessary tests.

(b) REPORT.—Not later than 3 years after the date of enactment of this Act, the entity conducting the study under subsection (a) shall submit to Congress and the Secretary of Health and Human Services a report on the study, together with recommendations for such legislation or administrative action as such entity determines appropriate.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 116. RULE OF CONSTRUCTION.

Nothing in the provisions of, or in the amendments made by, this subtitle shall be construed as requiring an individual to receive a geriatric assessment (as defined in section 1861(hhh)(1) of the Social Security Act, as added by section 111(b)) or chronic care management and co-

ordination services (as defined in section 1861(jjj)(1) of such Act, as added by section 112(b)).

TITLE II—AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT

SEC. 201. EXPANSION OF NATIONAL HEALTH SERVICE CORPS PROGRAMS.

(a) IN GENERAL.—Section 338H of the Public Health Service Act (42 U.S.C. 254q) is amended—

(1) in subsection (a), by striking paragraphs (1) through (5) and inserting the following:

''(1) for fiscal year 2009, $165,000,000;

''(2) for fiscal year 2010, $198,000,000;

''(3) for fiscal year 2011, $231,000,000;

''(4) for fiscal year 2012, $264,000,000;

''(5) for fiscal year 2013, $297,000,000; and

''(6) for fiscal year 2014, $330,000,000.''; and

(2) by adding at the end the following:

''(d) EXPANSION OF PROGRAMS.—The Secretary shall use amounts appropriated for each of fiscal years 2010 through 2014 under subsection (a), that are in excess of the amount appropriated under such subsection for fiscal year 2009, to address shortages of health professionals in rural, frontier, and urban underserved areas through an expansion of the number of scholarships and loan repayments under this subpart to address health

workforce shortages in health professional shortage areas (as defined in section 332), in medically underserved communities (as defined in section 799B), or with respect to medically underserved populations (as defined in section 330(b)(3)).''.

(b) EXPANSION OF OTHER PROGRAMS.—The Director of the Indian Health Service, the Secretary of Defense, and the Secretary of Veterans Affairs, shall expand existing loan repayment programs to emphasize the provision of health professions services to facilities that have health professional shortages.

(c) NO TAX IMPLICATIONS.—

(1) IN GENERAL.—For purposes of the Internal Revenue Code of 1986, any amount received under a health-related Federal loan repayment program by a health professional providing health-related services in a Federal medical facility shall not be included in the gross income of such professional.

(2) DEFINITION.—In this subsection, the term ''Federal medical facility'' means a facility for the delivery of health services, and includes—

(A) a federally qualified health center (as defined in section 330A of the Public Health Service Act (42 U.S.C. 254c)), a public health

center, an outpatient medical facility, or a community mental health center;

(B) a hospital, State mental hospital, facility for long-term care, or rehabilitation facility;

(C) a migrant health center or an Indian Health Service facility;

(D) a facility for the delivery of health services to inmates in a penal or correctional institution (under section 323 of such Act (42 U.S.C. 250)) or a State correctional institution;

(E) a Public Health Service medical facility (used in connection with the delivery of health services under section 320, 321, 322, 324, 325, or 326 of such Act (42 U.S.C. 247e, 248, 249, 251, 252, or 253));

(F) a nurse-managed health center; or

(G) any other Federal medical facility.

(d) REDUCED LOAN SUPPORT FOR PART TIME PRACTITIONERS.—Section 338C of the Public Health Service Act (42 U.S.C. 254m) is amended by adding at the end the following:

''(e) Notwithstanding any other provision of this subpart, the Secretary shall develop procedures to permit periods of obligated services to be provided on a part-time basis (not less than 1,040 hours of such service per year).

Such procedures shall prohibit an individual from holding other part-time employment while providing such part-time obligated services. The Secretary may provide for a reduction in the loan repayments provided to individuals who provide part-time obligated services under the authority provided under this subsection.''.

(e) LOAN SUPPORT FOR PARTICIPATING PRECEPTORS, MENTORS, AND ATTENDINGS TO SUPERVISE STUDENTS AND TRAINEES ON-SITE.—Section 338C of the Public Health Service Act (42 U.S.C. 254m), as amended by subsection (d), is further amended by adding at the end the following:

''(f) The Secretary shall develop procedures to permit up to 20 percent of the service obligation of an individual under this section to be provided by the individual through precepting or mentoring activities, or by preparing curriculum, for on-site students and trainees. The procedures developed under subsection (e) shall provide for the proportional application of this subsection with respect to individual providing obligated service on a part-time basis.''.

SEC. 202. NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP PROGRAM FOR MEDICAL, DENTAL, PHYSICIAN ASSISTANT, PHARMACY, BEHAVIORAL AND MENTAL HEALTH, PUBLIC HEALTH, AND NURSING STUDENTS IN THE UNITED STATES PUBLIC HEALTH SCIENCES TRACK IN AFFILIATED SCHOOLS.

(a) PROGRAM AUTHORIZED.—

(1) IN GENERAL.—Subpart III of part D of title III of the Public Health Service Act (42 U.S.C. 254l et seq.) is amended—

(A) in the heading by inserting "**, Scholarship Program for Medical, Dental, Physician Assistant, Pharmacy, Behavioral and Mental Health, Public Health, and Nursing Students in the United States Public Health Sciences Track in Affiliated Schools,**" after "**Scholarship Program**"; and

(B) by inserting after section 338A the following:

"SEC. 338A–1. NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP PROGRAM FOR MEDICAL, DENTAL, PHYSICIAN ASSISTANT, PHARMACY, BEHAVIORAL AND MENTAL HEALTH, PUBLIC HEALTH, AND NURSING STUDENTS IN THE UNITED STATES PUBLIC HEALTH SCIENCES TRACK IN AFFILIATED SCHOOLS.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary shall establish a program to be known as the National Health Service Corps Scholarship Program for Medical, Dental, Physician Assistant, Pharmacy, Behavioral and Mental Health, Public Health, and Nursing Students in the United States Public Health Sciences Track in Affiliated Schools (in this section referred to as the 'U.S. Public Health Sciences Track Scholarship Program') to ensure, with respect to the provision of high-needs health care services, including primary care, general dentistry, nursing, obstetrics, and geriatricians pursuant to section 331(a)(2), an adequate supply of physicians, physician assistants, pharmacists, behavioral and mental health professionals, public health professionals, dentists, and nurses. The purpose of this program is to train an additional 150 medical students, 100 dental students, 100 physician assistant students, 100 behav-

ioral and mental health students, 100 public health students, and 250 nursing students during each year. Of the 150 scholarships awarded to the medical students as described under the preceding sentence, 10 shall be for training at the Uniformed Services University of the Health Sciences as members of the Commissioned Corps of the Public Health Service.

''(2) RELATIONSHIP TO NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP PROGRAM.—Scholarships provided under this section are intended to complement, and not take the place of, scholarships provided to students enrolled in courses of study leading to a degree in medicine, osteopathic medicine, dentistry, or nursing or completion of an accredited physician assistant, pharmacy, public health, or behavioral and mental health educational program under the National Health Service Corps Scholarship Program authorized by section 338A.

''(b) ELIGIBILITY.—To be eligible to participate in the U.S. Public Health Sciences Track Scholarship and Grants Program, an individual shall—

''(1) be accepted for enrollment as a full-time student—

"(A) in an accredited (as determined by the Secretary) educational institution in a State; and

"(B) in a course of study, or program, offered by such institution leading to a degree in medicine, osteopathic medicine, dentistry, physician assistant, pharmacy, behavioral and mental health, public health, or nursing;

"(2) be eligible for, or hold, an appointment as a commissioned officer in the Regular or Reserve Corps of the Service or be eligible for selection for civilian service in the Corps;

"(3) submit an application to participate in the U.S. Public Health Sciences Track Scholarship and Grants Program; and

"(4) sign and submit to the Secretary, at the time of submittal of such application, a written contract to accept payment of a scholarship and to serve (in accordance with this subpart) for the applicable period of obligated service in an area in which the need for public health-related services may be demonstrated.".

(2) NO TAX IMPLICATIONS.—For purposes of the Internal Revenue Code of 1986, any amount received under the National Health Service Corps

Scholarship Program for Medical, Dental and Nursing Students in the United States Public Health Sciences Track in Affiliated Schools under section 338A–1 of the Public Health Service Act, as added by paragraph (1), by a medical student, dental student, or nursing student shall not be included in the gross income of such student.

(b) GRANTS TO INCREASE THE NUMBER OF AVAILABLE SLOTS FOR NEWLY ADMITTED MEDICAL, DENTAL, PHYSICIAN ASSISTANT, PHARMACY, BEHAVIORAL AND MENTAL HEALTH, PUBLIC HEALTH, AND NURSING STUDENTS AND TO INCREASE PARTICIPATION IN THE U.S. PUBLIC HEALTH SCIENCES TRACK SCHOLARSHIP PROGRAM.—Part C of title VII of the Public Health Service Act (42 U.S.C. 293k et seq.) is amended by adding at the end the following:

"SEC. 749. GRANTS TO INCREASE THE NUMBER OF AVAILABLE SLOTS FOR NEWLY ADMITTED MEDICAL, DENTAL, PHYSICIAN ASSISTANT, PHARMACY, BEHAVIORAL AND MENTAL HEALTH, PUBLIC HEALTH, AND NURSING STUDENTS AND TO INCREASE PARTICIPATION IN THE U.S. PUBLIC HEALTH SCIENCES TRACK SCHOLARSHIP PROGRAM.

''(a) PROGRAM AUTHORIZED.—The Secretary may make grants to medical, dental, public health, and nursing schools and physician assistant, pharmacy, and behavioral and mental health programs for the following purposes:

''(1) To increase the capacity of the recipient medical, dental, public health, or nursing school or physician assistant, pharmacy, or behavioral and mental health program, to accept additional medical, dental, public health, nursing, physician assistant, pharmacy, or behavioral and mental health students each year.

''(2) To develop curriculum.

''(3) To acquire equipment.

''(4) To recruit, train, and retain faculty.

''(5) To provide assistance to students who have completed a course of study at the recipient medical, dental, public health, or nursing school or physician assistant, pharmacy, or behavioral and mental health

program during the period in which such students are completing a residency or internship program affiliated with the recipient institution.

''(b) APPLICATION.—A medical, dental, public health, or nursing school or physician assistant, pharmacy, or behavioral and mental health program seeking a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(c) DEFINITION OF MEDICAL SCHOOL.—In this section, the term 'medical school' means a school of medicine or a school of osteopathic medicine.''.

SEC. 203. FEDERAL MEDICAL FACILITY GRANT PROGRAM AND PROGRAM ASSESSMENTS.

(a) FEDERAL MEDICAL FACILITY GRANT PROGRAM.—Title VII of the Public Health Service Act (42 U.S.C. 292 et seq.) is amended—

(1) by redesignating part F as part G; and

(2) by inserting after part E, the following:

"PART F—START-UP EXPENSES LOAN AND GRANT PROGRAMS FOR FEDERAL MEDICAL FACILITIES AND HOSPITALS STARTING HIGH NEEDS RESIDENCY PROGRAMS IN SHORTAGE AREAS

"SEC. 781. FEDERAL MEDICAL FACILITY GRANT PROGRAM.

''(a) IN GENERAL.—The Secretary shall award grants to eligible facilities to increase interdisciplinary, community-based health professions training in high-needs specialties for physicians, nurses, dentists, physician assistants, pharmacy, behavioral and mental health professionals, public health professionals, and other health professionals as determined appropriate by the Secretary, in consultation with the Permanent National Health Workforce Commission established under section 101(a) of the Health Access and Health Professions Supply Act of 2009.

''(b) ELIGIBLE FACILITIES; APPLICATION.—

''(1) DEFINITION OF ELIGIBLE FACILITY.—In this section, the term 'eligible facility'—

''(A) means a facility which—

''(i) is located in a health professional shortage area (as defined in section 332);

''(ii) is located in a medically underserved community (as defined in section 799B), or with respect to a medically un-

derserved population (as defined in section 330(b)(3));

''(iii) is a Federal medical facility;

''(iv) is an area health education center, a health education and training center, or a participant in the Quentin N. Burdick program for rural interdisciplinary training, that meet the requirements established by the Secretary; or

''(v) is establishing new residency programs in a specialty which the Secretary, in consultation with the Permanent National Health Workforce Commission established under section 101(a) of the Health Access and Health Professions Supply Act of 2009, determines is in high-need; and

''(B) includes Medicare certified Federally Qualified Health Centers, community health centers, health care for the homeless centers, rural health centers, migrant health centers, Indian Health Service entities, urban Indian centers, health clinics and hospitals operated by the Indian Health Service, Indian tribes and tribal organizations, and urban Indian organi-

zations (as defined in section 4 of the Indian Health Care Improvement Act), and other Federal medical facilities).

''(2) APPLICATION.—An eligible facility desiring a grant under subsection (a) shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—An eligible facility shall use amounts received under a grant under subsection (a) to promote—

''(1) the training of health professionals in interdisciplinary, community-based settings that are affiliated with hospitals and other health care facilities and teaching institutions;

''(2) community development programs that assure a diverse health professions workforce through emphasis on individuals from rural and frontier areas and underrepresented minority groups;

''(3) the development of a reliable health professions pipeline that provides an emphasis on health-related careers in schools (such as schools participating in the Health Careers Opportunities Program) and centers of excellence, and that encourage individuals in underrepresented minorities (including

Hispanic, African-American, American Indian, and Alaska Native individuals) to pursue health professions careers;

''(4) the reduction of health professional isolation in rural, frontier, and urban underserved areas through the provision of continuing education, mentoring, and precepting activities, field faculty development, and the utilization of technology such as telehealth and electronic health records;

''(5) the establishment and operation of regional or statewide health advice telephone lines to reduce after-hours call responsibilities for overworked health professionals who provide services in remote areas that have few health professionals taking such after-hours calls;

''(6) an increase in the number of professionals taking after-hours calls in hospitals and emergency departments in health professional shortage areas (as defined in section 332), in medically underserved communities (as defined in section 799B), or with respect to medically underserved populations (as defined in section 330(b)(3));

''(7) the establishment and operation of relief programs that provide health professionals practicing in health professional shortage areas (as de-

fined in section 332) with patient and call coverage when such professionals are ill, are pursuing continuing education, or are taking a vacation; and

''(8) the exposure of health professions residents to systems of health care that represent the contemporary American healthcare delivery program (such as 'P4' Prepare the Personal Physician for Practice and the 'Health Commons' programs).

''(d) SUBGRANTS.—An eligible facility may use amounts received under a grant under this section to award subgrants to States and other entities determined appropriate by the Secretary to carry out the activities described in subsection (c).

''(e) SET ASIDE.—In awarding grants under this section, the Secretary shall ensure that a total of $500,000 is awarded annually for the activities of the National Rural Recruitment and Retention Network, or a similar entity.

''(f) DEFINITION OF FEDERAL MEDICAL FACILITY.—In this section, the term 'Federal medical facility' means a facility for the delivery of health services, and includes—

''(1) a federally qualified health center (as defined in section 330A), a public health center, an

outpatient medical facility, or a community mental health center;

''(2) a hospital, State mental hospital, facility for long-term care, or rehabilitation facility;

''(3) a migrant health center or an Indian Health Service facility;

''(4) a facility for the delivery of health services to inmates in a penal or correctional institution (under section 323) or a State correctional institution;

''(5) a Public Health Service medical facility (used in connection with the delivery of health services under section 320, 321, 322, 324, 325, or 326)); or

''(6) any other Federal medical facility.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $623,000,000 for fiscal year 2009, $666,000,000 for fiscal year 2010, $675,000,000 for fiscal year 2011, $700,000,000 for fiscal year 2012, and $725,000,000 for fiscal year 2013.''.

(b) ASSESSMENTS.—

(1) ESTABLISHMENT.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish program assessment

rating tools for each program funded through titles VII and VIII of the Public Health Service Act (42 U.S.C. 292 and 296 et seq.).

(2) CRITERIA.—The Secretary, in consultation with the Administrator of the Health Resources and Services Administration and other appropriate public and private stakeholders, shall, through negotiated rulemaking, establish criteria for the conduct of the assessments under paragraph (2).

(3) ANNUAL ASSESSMENTS.—The Secretary shall annually enter into a contract with an independent nongovernmental entity for the conduct of an assessment, using the tools established under paragraph (1) and the criteria established under paragraph (2), of not less than 20 percent, nor more than 25 percent, of the programs carried out under titles VII and VIII of the Public Health Service Act, so that every program under such titles is assessed at least once during every 5-year period.

SEC. 204. HEALTH PROFESSIONS TRAINING LOAN PROGRAM.

Part F of title VII of the Public Health Service Act (as added by section 203) is amended by adding at the end the following

"SEC. 782. ESTABLISHMENT.

''(a) IN GENERAL.—The Secretary shall establish a program under which the Secretary shall award interest-free loans to—

''(1) eligible hospitals to enable such hospitals to establish training programs in high-need specialties; and

''(2) eligible non-hospital community-based entities to enable such entities to establish health professions training programs.

''(b) ELIGIBILITY.—

''(1) IN GENERAL.—To be eligible to receive a loan under subsection (a)—

''(A) a hospital shall—

''(i) be located in a health professional shortage area (as such term is defined in section 332);

''(ii) comply with the requirements of paragraph (2); and

''(iii) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require; or

''(B) a non-hospital community-based entity shall—

"(i) comply with the requirements of paragraph (2); and

"(ii) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

"(2) REQUIREMENTS.—To be eligible to receive a loan under subsection (a), a hospital or non-hospital community-based entity shall—

"(A) on the date on which the entity submits the loan application, not operate a residency with respect to a high-needs specialty (as determined by the Secretary in consultation with the Permanent National Health Workforce Commission established under section 101(a) of the Health Access and Health Professions Supply Act of 2009) or provide a health professions training program, as the case may be;

"(B) have received appropriate preliminary accreditation from the relevant accrediting agency (American Council for Graduate Medical Education, American Osteopathic Association, or Dental, Physician Assistant, Pharmacy, Behavioral and Mental Health, Public Health, and

Nursing accrediting agencies), as determined by the Secretary; and

''(C) execute a signed formal contract under which the hospital or entity agree to repay the loan.

''(c) USE OF LOAN FUNDS.—Amounts received under a loan under subsection (a) shall be used only for—

''(1) the salary and fringe benefit expenses of residents, students, trainees, and faculty, or other costs directly attributable to the residency, educational, or training program to be carried out under the loan, as specified by the Secretary; or

''(2) facility construction or renovation, including equipment purchase.

''(d) PRIORITY.—In awarding loans under subsection (a), the Secretary shall give priority to applicants that are located in health professional shortage areas (as defined in section 332) or in medically underserved communities (as defined in section 799B), or that serve medically underserved populations (as defined in section 330(b)(3)).

''(e) LOAN PROVISIONS.—

''(1) LOAN CONTRACT.—The loan contract entered into under subsection (b)(2) shall contain terms that provide for the repayment of the loan, including the number and amount of installment pay-

ments as described in such contract. Such repayment shall begin on the date that is 24 months after the date on which the loan contract is executed and shall be fully repaid not later than 36 months after the date of the first payment.

''(2) INTEREST.—Loans under this section shall be repaid without interest.

''(f) LIMITATION.—The amount of a loan under this section with respect to each of the uses described in subsection (c)(1) or (c)(2) shall not exceed $2,000,000.

''(g) FAILURE TO REPAY.—A hospital or non-hospital community-based entity that fails to comply with the terms of a contract entered into under subsection (b)(2) shall be liable to the United States for the amount which has been paid to such hospital or entity under the contract.

''(h) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, such sums as may be necessary to carry out this section.''.

SEC. 205. UNITED STATES PUBLIC HEALTH SCIENCES TRACK.

Title II of the Public Health Service Act (42 U.S.C. 202 et seq.) is amended by adding at the end the following:

"PART D—UNITED STATES PUBLIC HEALTH SCIENCES TRACK

"SEC. 271. ESTABLISHMENT.

''(a) UNITED STATES PUBLIC HEALTH SERVICES TRACK.—

''(1) IN GENERAL.—There is hereby authorized to be established a United States Public Health Sciences Track (referred to in this part as the 'Track'), at sites to be selected by the Secretary, with authority to grant appropriate advanced degrees in a manner that uniquely emphasizes team-based service, public health, epidemiology, and emergency preparedness and response. It shall be so organized as to graduate not less than—

''(A) 150 medical students annually;

''(B) 100 dental students annually;

''(C) 250 nursing students annually;

''(D) 100 public health students annually;

''(E) 100 behavioral and mental health professional students annually;

''(F) 100 physician assistant or nurse practitioner students annually; and

''(G) 50 pharmacy students annually.

''(2) LOCATIONS.—The Track shall be located at existing and accredited, affiliated health professions education training programs at academic

health centers located in regions of the United States determined appropriate by the Surgeon General, in consultation with the Permanent National Health Workforce Commission.

''(b) NUMBER OF GRADUATES.—Except as provided in subsection (a), the number of persons to be graduated from the Track shall be prescribed by the Secretary. In so prescribing the number of persons to be graduated from the Track, the Secretary shall institute actions necessary to ensure the maximum number of first-year enrollments in the Track consistent with the academic capacity of the affiliated sites and the needs of the United States for medical, dental, and nursing personnel.

''(c) DEVELOPMENT.—The development of the Track may be by such phases as the Secretary may prescribe subject to the requirements of subsection (a).

''(d) INTEGRATED LONGITUDINAL PLAN.—The Surgeon General shall develop an integrated longitudinal plan for health professions continuing education throughout the continuum of health-related education, training, and practice. Training under such plan shall emphasize patient-centered, interdisciplinary, and care coordination skills. Experience with deployment of emergency response teams shall be included during the clinical experiences.

''(e) FACULTY DEVELOPMENT.—The Surgeon General shall develop faculty development programs and curricula in decentralized venues of health care, to balance urban, tertiary, and inpatient venues.

"SEC. 272. ADMINISTRATION.

''(a) IN GENERAL.—The business of the Track shall be conducted by the Surgeon General with funds appropriated for and provided by the Department of Health and Human Services. The Permanent National Health Workforce Commission shall assist the Surgeon General in an advisory capacity.

''(b) FACULTY.—

''(1) IN GENERAL.—The Surgeon General, after considering the recommendations of the Permanent National Health Workforce Commission, shall obtain the services of such professors, instructors, and administrative and other employees as may be necessary to operate the Track, but utilize when possible, existing affiliated health professions training institutions. Members of the faculty and staff shall be employed under salary schedules and granted retirement and other related benefits prescribed by the Secretary so as to place the employees of the Track faculty on a comparable basis with the employees of

fully accredited schools of the health professions within the United States.

''(2) TITLES.—The Surgeon General may confer academic titles, as appropriate, upon the members of the faculty.

''(3) NONAPPLICATION OF PROVISIONS.—The limitations in section 5373 of title 5, United States Code, shall not apply to the authority of the Surgeon General under paragraph (1) to prescribe salary schedules and other related benefits.

''(c) AGREEMENTS.—The Surgeon General may negotiate agreements with agencies of the Federal Government to utilize on a reimbursable basis appropriate existing Federal medical resources located in the United States (or locations selected in accordance with section 271(a)(2)). Under such agreements the facilities concerned will retain their identities and basic missions. The Surgeon General may negotiate affiliation agreements with accredited universities and health professions training institutions in the United States. Such agreements may include provisions for payments for educational services provided students participating in Department of Health and Human Services educational programs.

''(d) PROGRAMS.—The Surgeon General may establish the following educational programs for Track students:

''(1) Postdoctoral, postgraduate, and technological institutes.

''(2) A graduate school of nursing.

''(3) Other schools or programs that the Surgeon General determines necessary in order to operate the Track in a cost-effective manner.

''(e) CONTINUING MEDICAL EDUCATION.—The Surgeon General shall establish programs in continuing medical education for members of the health professions to the end that high standards of health care may be maintained within the United States.

''(f) AUTHORITY OF THE SURGEON GENERAL.—

''(1) IN GENERAL.—The Surgeon General is authorized—

''(A) to enter into contracts with, accept grants from, and make grants to any nonprofit entity for the purpose of carrying out cooperative enterprises in medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing research, consultation, and education;

"(B) to enter into contracts with entities under which the Surgeon General may furnish the services of such professional, technical, or clerical personnel as may be necessary to fulfill cooperative enterprises undertaken by the Track;

"(C) to accept, hold, administer, invest, and spend any gift, devise, or bequest of personal property made to the Track, including any gift, devise, or bequest for the support of an academic chair, teaching, research, or demonstration project;

"(D) to enter into agreements with entities that may be utilized by the Track for the purpose of enhancing the activities of the Track in education, research, and technological applications of knowledge; and

"(E) to accept the voluntary services of guest scholars and other persons.

"(2) LIMITATION.—The Surgeon General may not enter into any contract with an entity if the contract would obligate the Track to make outlays in advance of the enactment of budget authority for such outlays.

''(3) SCIENTISTS.—Scientists or other medical, dental, or nursing personnel utilized by the Track under an agreement described in paragraph (1) may be appointed to any position within the Track and may be permitted to perform such duties within the Track as the Surgeon General may approve.

''(4) VOLUNTEER SERVICES.—A person who provides voluntary services under the authority of subparagraph (E) of paragraph (1) shall be considered to be an employee of the Federal Government for the purposes of chapter 81 of title 5, relating to compensation for work-related injuries, and to be an employee of the Federal Government for the purposes of chapter 171 of title 28, relating to tort claims. Such a person who is not otherwise employed by the Federal Government shall not be considered to be a Federal employee for any other purpose by reason of the provision of such services.

''SEC. 273. STUDENTS; SELECTION; OBLIGATION.

''(a) STUDENT SELECTION.—

''(1) IN GENERAL.—Medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students at the Track shall be selected under procedures prescribed by the Surgeon General. In so prescribing, the Surgeon

General shall consider the recommendations of the Permanent National Health Workforce Commission.

''(2) PRIORITY.—In developing admissions procedures under paragraph (1), the Surgeon General shall ensure that such procedures give priority to applicant medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students from rural communities and underrepresented minorities.

''(b) CONTRACT AND SERVICE OBLIGATION.—

''(1) CONTRACT.—Upon being admitted to the Track, a medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, or nursing student shall enter into a written contract with the Surgeon General that shall contain—

''(A) an agreement under which—

''(i) subject to subparagraph (B), the Surgeon General agrees to provide the student with tuition (or tuition remission) and a student stipend (described in paragraph (2)) in each school year for a period of years (not to exceed 4 school years) determined by the student, during which period the student is enrolled in the Track at an affiliated or other participating health pro-

fessions institution pursuant to an agreement between the Track and such institution; and

''(ii) subject to subparagraph (B), the student agrees—

''(I) to accept the provision of such tuition and student stipend to the student;

''(II) to maintain enrollment at the Track until the student completes the course of study involved;

''(III) while enrolled in such course of study, to maintain an acceptable level of academic standing (as determined by the Surgeon General);

''(IV) if pursuing a degree from a school of medicine or osteopathic medicine, dental, public health, or nursing school or a physician assistant, pharmacy, or behavioral and mental health professional program, to complete a residency or internship in a specialty that the Surgeon General determines is appropriate; and

"(V) to serve for a period of time (referred to in this part as the 'period of obligated service') within the Commissioned Corps of the Public Health Service equal to 2 years for each school year during which such individual was enrolled at the College, reduced as provided for in paragraph (3);

"(B) a provision that any financial obligation of the United States arising out of a contract entered into under this part and any obligation of the student which is conditioned thereon, is contingent upon funds being appropriated to carry out this part;

"(C) a statement of the damages to which the United States is entitled for the student's breach of the contract; and

"(D) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with the provisions of this part.

"(2) TUITION AND STUDENT STIPEND.—

"(A) TUITION REMISSION RATES.—The Surgeon General, based on the recommenda-

tions of the Permanent National Health Workforce Commission established under section 101(a) of the Health Access and Health Professions Supply Act of 2009, shall establish Federal tuition remission rates to be used by the Track to provide reimbursement to affiliated and other participating health professions institutions for the cost of educational services provided by such institutions to Track students. The agreement entered into by such participating institutions under paragraph (1)(A)(i) shall contain an agreement to accept as payment in full the established remission rate under this subparagraph.

''(B) STIPEND.—The Surgeon General, based on the recommendations of the Permanent National Health Workforce Commission, shall establish and update Federal stipend rates for payment to students under this part.

''(3) REDUCTIONS IN THE PERIOD OF OBLIGATED SERVICE.—The period of obligated service under paragraph (1)(A)(ii)(V) shall be reduced—

''(A) in the case of a student who elects to participate in a high-needs speciality residency (as determined by the Permanent National

Health Workforce Commission), by 3 months for each year of such participation (not to exceed a total of 12 months); and

"(B) in the case of a student who, upon completion of their residency, elects to practice in a Federal medical facility (as defined in section 781(e)) that is located in a health professional shortage area (as defined in section 332), by 3 months for year of full-time practice in such a facility (not to exceed a total of 12 months).

"(c) SECOND 2 YEARS OF SERVICE.—During the third and fourth years in which a medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, or nursing student is enrolled in the Track, training should be designed to prioritize clinical rotations in Federal medical facilities in health professional shortage areas, and emphasize a balance of hospital and community-based experiences, and training within interdisciplinary teams.

"(d) DENTIST, PHYSICIAN ASSISTANT, PHARMACIST, BEHAVIORAL AND MENTAL HEALTH PROFESSIONAL, PUBLIC HEALTH PROFESSIONAL, AND NURSE TRAINING.—The Surgeon General shall establish provisions applicable with respect to dental, physician assistant, phar-

macy, behavioral and mental health, public health, and nursing students that are comparable to those for medical students under this section, including service obligations, tuition support, and stipend support. The Surgeon General shall give priority to health professions training institutions that train medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students for some significant period of time together, but at a minimum have a discrete and shared core curriculum.

''(e) ELITE FEDERAL DISASTER TEAMS.—The Surgeon General, in consultation with the Secretary, the Director of the Centers for Disease Control and Prevention, and other appropriate military and Federal government agencies, shall develop criteria for the appointment of highly qualified Track faculty, medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students, and graduates to elite Federal disaster preparedness teams to train and to respond to public health emergencies, natural disasters, bioterrorism events, and other emergencies.

''(f) STUDENT DROPPED FROM TRACK IN AFFILIATE SCHOOL.—A medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, or nursing student who, under regulations prescribed by the

Surgeon General, is dropped from the Track in an affiliated school for deficiency in conduct or studies, or for other reasons, shall be liable to the United States for all tuition and stipend support provided to the student.

''SEC. 274. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated to carry out this part, section 338A–1, and section 749, such sums as may be necessary.''.

SEC. 206. MEDICAL EDUCATION DEBT REIMBURSEMENT FOR PHYSICIANS OF THE VETERANS HEALTH ADMINISTRATION.

(a) IN GENERAL.—The Secretary of Veterans Affairs shall carry out a program under which eligible physicians described in subsection (b) are reimbursed for the education debt of such physicians as described in subsection (c).

(b) ELIGIBLE PHYSICIANS.—An eligible physician described in this subsection is any physician currently appointed to a physician position in the Veterans Health Administration under section 7402(b)(1) of title 38, United States Code, who enters into an agreement with the Secretary to continue serving as a physician in such position for such period of time as the Secretary shall specify in the agreement.

(c) COVERED EDUCATION DEBT.—The education debt for which an eligible physician may be reimbursed under this section is any amount paid by the physician for tuition, room and board, or expenses in obtaining the degree of doctor or medicine or of doctor of osteopathy, including any amounts of principal or interest paid by the physician under a loan, the proceeds of which were used by or on behalf of the physician for the costs of obtaining such degree.

(d) FREQUENCY OF REIMBURSEMENT.—Any reimbursement of an eligible physician under this section shall be made in a lump sum or in installments of such frequency as the Secretary shall specify the agreement of the physician as required under subsection (b).

(e) LIABILITY FOR FAILURE TO COMPLETE OBLIGATED SERVICE.—Any eligible physician who fails to satisfactorily complete the period of service agreed to by the physician under subsection (b) shall be liable to the United States in an amount determined in accordance with the provisions of section 7617(c)(1) of title 38, United States Code.

(f) TREATMENT OF REIMBURSEMENT WITH OTHER PAY AND BENEFIT AUTHORITIES.—Any amount of reimbursement payable to an eligible physician under this section is in addition to any other pay, allowances, or benefits

that may be provided the physician under law, including any educational assistance under the Department of Veterans Affairs Health Professional Educational Assistance Program under chapter 76 of title 38, United States Code.

SEC. 207. PROMOTING EDUCATION AND TRAINING OF PSYCHOLOGISTS TO PROVIDE MENTAL AND BEHAVIORAL HEALTH SERVICES TO UNDERSERVED POPULATIONS.

Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.) is amended by adding at the end the following:

"Subpart 3—Mental and Behavioral Health Care Workforce

"SEC. 775. PROGRAM FOR GRADUATE EDUCATION AND TRAINING IN PSYCHOLOGY.

''(a) IN GENERAL.—The Secretary may award grants, cooperative agreements, and contracts to accredited doctoral, internship, and residency programs in psychology for the development and implementation of programs to provide interdisciplinary training in integrated health care settings to students in doctoral psychology programs, including interns and residents in such programs. Any training funded by such grants, cooperative agreements, or contracts shall focus on the needs of underserved populations.

''(b) ELIGIBILITY.—To be eligible to receive an award under this section an entity shall—

''(1) provide training at or through an accredited doctoral program in psychology, including an internship or residency program; and

''(2) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) EVALUATION OF PROGRAMS.—The Secretary shall evaluate any program implemented through an award under this section in order to determine the effect of such program on increasing the number of psychologists who provide mental and behavioral health services to underserved populations.

''(d) DEFINITIONS.—For purposes of this section—

''(1) the term 'underserved population' means individuals, especially older adults, children, chronically ill individuals, victims of abuse or trauma, and victims of combat- or war-related stress disorders, including post-traumatic stress disorder and traumatic brain injury, and their families, living in an urban or rural area that has a shortage of mental or behavioral health services; and

''(2) the term 'interdisciplinary training' means training for graduate psychology students with 1 or more of the other health professions, including medicine, nursing, dentistry, and pharmacy.

''(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $10,000,000 for fiscal year 2010, $12,000,000 for fiscal year 2011, $14,000,000 for fiscal year 2012, $16,000,000 for fiscal year 2013, and $18,000,000 for fiscal year 2014.''.

TITLE III—HEALTH PROFESSIONAL TRAINING PIPELINE PARTNERSHIPS PROGRAM

SEC. 301. GRANTS TO PREPARE STUDENTS FOR CAREERS IN HEALTH CARE.

(a) PURPOSE.—The purpose of this section is to support the development and implementation of programs designed to prepare middle school and high school students for study and careers in the healthcare field, including success in postsecondary mathematics and science programs.

(b) DEFINITIONS.—In this section:

(1) CHILDREN FROM LOW-INCOME FAMILIES.—The term ''children from low-income families'' means children described in section 1124(c)(1)(A) of

the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6333(c)(1)(A)).

(2) ELIGIBLE RECIPIENTS.—The term ''eligible recipient'' means—

(A) a nonprofit healthcare career pathway partnership organization; or

(B) a high-need local educational agency in partnership with—

(i) not less than 1 institution of higher education with an established health profession education program; and

(ii) not less than 1 community-based, private sector healthcare provider organization.

(3) HIGH-NEED LOCAL EDUCATIONAL AGENCY.—The term ''high-need local educational agency'' means a local educational agency or educational service agency—

(A) that serves not fewer than 10,000 children from low-income families;

(B) for which not less than 20 percent of the children served by the agency are children from low-income families;

(C) that meets the eligibility requirements for funding under the Small, Rural School

Achievement Program under section 6211(b) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7345(b)); or

(D) that meets the eligibility requirements for funding under the Rural and Low-Income School Program under section 6221(b)(1) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7351(b)(1)).

(4) NONPROFIT HEALTHCARE CAREER PATHWAY PARTNERSHIP ORGANIZATION.—The term ''nonprofit healthcare career pathway partnership organization'' means a nonprofit organization focused on developing career and educational pathways to healthcare professions, that shall include representatives of—

(A) the local educational agencies;

(B) not less than 1 institution of higher education (as defined in section 101(a) of the Higher Education Act of 1965 (20 U.S.C. 1001(a))) with an established health profession education program; and

(C) not less than 1 community-based, private sector healthcare provider organization or other healthcare industry organization.

(5) SECRETARY.—The term ''Secretary'' means the Secretary of Education.

(c) GRANTS AUTHORIZED.—

(1) IN GENERAL.—The Secretary is authorized to award grants, on a competitive basis, to eligible recipients to enable the recipients to develop and implement programs of study to prepare middle school and high school students for postsecondary education leading to careers in the healthcare field.

(2) MINIMUM FUNDING LEVEL.—Grants shall be awarded at a minimum level of $500,000 per recipient, per year.

(3) RENEWABILITY.—Grants may be renewed, at the discretion of the Secretary, for not more than 5 years.

(d) APPLICATION.—Each eligible recipient desiring a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, which shall include an assurance that the recipient will meet the program requirements described in subsection (f)(2).

(e) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to—

(1) applicants that include a local educational agency that is located in an area that is designated

under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)) as a health professional shortage area;

(2) applicants that include an institution of higher education that emphasizes an interdisciplinary approach to health profession education; and

(3) applicants whose program involves the development of a uniquely innovative public-private partnership.

(f) AUTHORIZED ACTIVITIES/USE OF FUNDS.—

(1) IN GENERAL.—Each eligible recipient that receives a grant under this section shall use the grant funds to develop and implement programs of study to prepare middle school and high school students for careers in the healthcare field that—

(A) are aligned with State challenging academic content standards and State challenging student academic achievement standards; and

(B) lead to high school graduation with the skills and preparation—

(i) to enter postsecondary education programs of study in mathematics and science without remediation; and

(ii) necessary to enter healthcare jobs directly.

(2) PROGRAM REQUIREMENTS.—A program of study described in paragraph (1) shall—

(A) involve a review and identification of the content knowledge and skills students who enter institutions of higher education and the workforce need to have in order to succeed in the healthcare field;

(B) promote the alignment of mathematics and science curricula and assessments in middle school and high school and facilitate learning of the required knowledge and skills identified in subparagraph (A);

(C) include an outreach component to educate middle school and high school students and their parents about the full range of employment opportunities in the healthcare field, specifically in the local community;

(D) include specific opportunities for youth to interact with healthcare professionals or industry representatives in the classroom, school, or community locations and how these experiences will be integrated with coursework;

(E) include high-quality volunteer or internship experiences, integrated with coursework;

(F) provide high-quality mentoring, counseling, and career counseling support services to program participants;

(G) consider the inclusion of a distance-learning component or similar education technology that would expand opportunities for geographically isolated individuals;

(H) encourage the participation of individuals who are members of groups that are underrepresented in postsecondary education programs in mathematics and science;

(I) encourage participants to seek work in communities experiencing acute health professional shortages; and

(J) collect data, and analyze the data using measurable objectives and benchmarks, to evaluate the extent to which the program succeeded in—

(i) increasing student and parent awareness of occupational opportunities in the healthcare field;

(ii) improving student academic achievement in mathematics and science;

(iii) increasing the number of students entering health care professions upon graduation; and

(iv) increasing the number of students pursuing secondary education or training opportunities with the potential to lead to a career in the healthcare field.

(3) PLANNING GRANT SET ASIDE.—Each eligible recipient that receives a grant under this section shall set aside 10 percent of the grant funds for planning and program development purposes.

(g) MATCHING REQUIREMENT.—Each eligible recipient that receives a grant under this section shall provide, from the private sector, an amount equal to 40 percent of the amount of the grant, in cash or in kind, to carry out the activities supported by the grant.

(h) REPORTS.—

(1) ANNUAL EVALUATION.—Each eligible recipient that receives a grant under this section shall collect and report to the Secretary annually such information as the Secretary may reasonably require, including—

(A) the number of schools involved and student participants in the program;

(B) the race, gender, socio-economic status, and disability status of program participants;

(C) the number of program participants who successfully graduated from high school;

(D) the number of program participants who reported enrollment in some form of post-secondary education with the potential to lead to a career in the healthcare field;

(E) the number of program participants who entered a paid position, either part-time or full-time, in the healthcare field following participation in the program; and

(F) the data and analysis required under subsection (f)(2)(J).

(2) REPORT.—Not later than 3 years after the date of enactment of this section, the Secretary shall submit to Congress an interim report on the results of the evaluations conducted under paragraph (1).

(i) AUTHORIZATION AND APPROPRIATION.—

(1) IN GENERAL.—There are authorized to be appropriated $100,000,000 for each of fiscal years 2009 through 2013 to carry out this section.

(2) ADMINISTRATIVE COSTS.—For the costs of administering this section, including the costs of

evaluating the results of grants and submitting reports to the Congress, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2009 through 2013.

○