111TH CONGRESS
1ST SESSION

S. 1174

To amend the Public Health Service Act and the Social Security Act to increase the number of primary care physicians and primary care providers and to improve patient access to primary care services, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 3, 2009

Ms. CANTWELL (for herself, Ms. COLLINS, and Mr. WHITEHOUSE) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend the Public Health Service Act and the Social Security Act to increase the number of primary care physicians and primary care providers and to improve patient access to primary care services, and for other purposes.

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 ''Preserving Patient Access to Primary Care Act of 2009''.

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

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Approximately 21 percent of physicians who were board certified in general internal medicine during the early 1990s have left internal medicine, compared to a 5 percent departure rate for those who were certified in subspecialties of internal medicine.

(2) The number of United States medical graduates going into family medicine has fallen by more than 50 percent from 1997 to 2005.

(3) In 2007, only 88 percent of the available medicine residency positions were filled and only 42 percent of those were filled by United States medical school graduates.

(4) In 2006, only 24 percent of third-year internal medicine resident intended to pursue careers in

general internal medicine, down from 54 percent in 1998.

(5) Primary care physicians serve as the point of first contact for most patients and are able to coordinate the care of the whole person, reducing unnecessary care and duplicative testing.

(6) Primary care physicians and primary care providers practicing preventive care, including screening for illness and treating diseases, can help prevent complications that result in more costly care.

(7) Patients with primary care physicians or primary care providers have lower health care expenditures and primary care is correlated with better health status, lower overall mortality, and longer life expectancy.

(8) Higher proportions of primary care physicians are associated with significantly reduced utilization.

(9) The United States has a higher ratio of specialists to primary care physicians than other industrialized nations and the population of the United States is growing faster than the expected rate of growth in the supply of primary care physicians.

(10) The number of Americans age 65 and older, those eligible for Medicare and who use far more ambulatory care visits per person as those under age 65, is expected to double from 2000 to 2030.

(11) A decrease in Federal spending to carry out programs authorized by title VII of the Public Health Service Act threatens the viability of one of the programs used to solve the problem of inadequate access to primary care.

(12) The National Health Service Corps program has a proven record of supplying physicians to underserved areas, and has played an important role in expanding access for underserved populations in rural and inner city communities.

(13) Individuals in many geographic areas, especially rural areas, lack adequate access to high quality preventive, primary health care, contributing to significant health disparities that impair America's public health and economic productivity.

(14) About 20 percent of the population of the United States resides in primary medical care Health Professional Shortage Areas.

SEC. 3. DEFINITIONS.

(a) GENERAL DEFINITIONS.—In this Act:

(1) CHRONIC CARE COORDINATION.—The term ''chronic care coordination'' means the coordination of services that is based on the Chronic Care Model that provides on-going health care to patients with chronic diseases that may include any of the following services:

(A) The development of an initial plan of care, and subsequent appropriate revisions to such plan of care.

(B) The management of, and referral for, medical and other health services, including interdisciplinary 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.

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

(G) Providing access by telephone with physicians and other appropriate health care

professionals, including 24-hour availability of such professionals for emergencies.

(H) Management with the principal non-professional caregiver in the home.

(I) Managing and facilitating transitions 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, and referral to, hospice care, including patient and family caregiver education and counseling about hospice care, and facilitating transition to hospice care when elected.

(K) Information about, referral to, and management with, community services.

(2) CRITICAL SHORTAGE HEALTH FACILITY.—The term ''critical shortage health facility'' means a public or private nonprofit health facility that does not serve a health professional shortage area (as designated under section 332 of the Public Health Service Act), but that has a critical shortage of phy-

sicians (as determined by the Secretary) in a primary care field.

(3) PHYSICIAN.—The term physician has the meaning given such term in section 1861(r)(1) of the Social Security Act.

(4) PRIMARY CARE.—The term ''primary care'' means the provision of integrated, high-quality, accessible health care services by health care providers who are accountable for addressing a full range of personal health and health care needs, developing a sustained partnership with patients, practicing in the context of family and community, and working to minimize disparities across population subgroups.

(5) PRIMARY CARE FIELD.—The term ''primary care field'' means any of the following fields:

(A) The field of family medicine.

(B) The field of general internal medicine.

(C) The field of geriatric medicine.

(D) The field of pediatric medicine

(6) PRIMARY CARE PHYSICIAN.—The term ''primary care physician'' means a physician who is trained in a primary care field who provides first contact, continuous, and comprehensive care to patients.

(7) PRIMARY CARE PROVIDER.—The term ''primary care provider'' means—

(A) a nurse practitioner; or

(B) a physician assistant practicing as a member of a physician-directed team;

who provides first contact, continuous, and comprehensive care to patients.

(8) PRINCIPAL CARE.—The term ''principal care'' means integrated, accessible health care that is provided by a physician who is a medical subspecialist that addresses the majority of the personal health care needs of patients with chronic conditions requiring the subspecialist's expertise, and for whom the subspecialist assumes care management, developing a sustained physician-patient partnership and practicing within the context of family and community.

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

(b) PRIMARY MEDICAL CARE SHORTAGE AREA.—

(1) IN GENERAL.—In this Act, the term ''primary medical care shortage area'' or ''PMCSA'' means a geographic area with a shortage of physicians (as designated by the Secretary) in a primary

care field, as designated in accordance with paragraph (2).

(2) DESIGNATION.—To be designated by the Secretary as a PMCSA, the Secretary must find that the geographic area involved has an established shortage of primary care physicians for the population served. The Secretary shall make such a designation with respect to an urban or rural geographic area if the following criteria are met:

(A) The area is a rational area for the delivery of primary care services.

(B) One of the following conditions prevails within the area:

(i) The area has a population to full-time-equivalent primary care physician ratio of at least 3,500 to 1.

(ii) The area has a population to full-time-equivalent primary care physician ratio of less than 3,500 to 1 and has unusually high needs for primary care services or insufficient capacity of existing primary care providers.

(C) Primary care providers in contiguous geographic areas are overutilized.

(c) MEDICALLY UNDERSERVED AREA.—

(1) IN GENERAL.—In this Act, the term ''medically underserved area'' or ''MUA'' means a rational service area with a demonstrable shortage of primary health care resources relative to the needs of the entire population within the service area as determined in accordance with paragraph (2) through the use of the Index of Medical Underservice (referred to in this subsection as the ''IMU'') with respect to data on a service area.

(2) DETERMINATIONS.—Under criteria to be established by the Secretary with respect to the IMU, if a service area is determined by the Secretary to have a score of 62.0 or less, such area shall be eligible to be designated as a MUA.

(3) IMU VARIABLES.—In establishing criteria under paragraph (2), the Secretary shall ensure that the following variables are utilized:

(A) The ratio of primary medical care physicians per 1,000 individuals in the population of the area involved.

(B) The infant mortality rate in the area involved.

(C) The percentage of the population involved with incomes below the poverty level.

(D) The percentage of the population involved age 65 or over.

The value of each of such variables for the service area involved shall be converted by the Secretary to a weighted value, according to established criteria, and added together to obtain the area's IMU score.

(d) PATIENT CENTERED MEDICAL HOME.—

(1) IN GENERAL.—In this Act, the term ''patient centered medical home'' means a physician-directed practice (or a nurse practitioner-directed practice in those States in which such functions are included in the scope of practice of licensed nurse practitioners) that has been certified by an organization under paragraph (3) as meeting the following standards:

(A) The practice provides patients who elect to obtain care through a patient centered medical home (referred to as ''participating patients'') with direct and ongoing access to a primary or principal care physician or a primary care provider who accepts responsibility for providing first contact, continuous, and comprehensive care to the whole person, in collaboration with teams of other health professionals, includ-

ing nurses and specialist physicians, as needed and appropriate.

(B) The practice applies standards for access to care and communication with participating beneficiaries.

(C) The practice has readily accessible, clinically useful information on participating patients that enables the practice to treat such patients comprehensively and systematically.

(D) The practice maintains continuous relationships with participating patients by implementing evidence-based guidelines and applying such guidelines to the identified needs of individual beneficiaries over time and with the intensity needed by such beneficiaries.

(2) RECOGNITION OF NCQA APPROVAL.—Such term also includes a physician-directed (or nurse-practitioner-directed) practice that has been recognized as a medical home through the Physician Practice Connections—patient centered Medical Home (''PPC–PCMH'') voluntary recognition process of the National Committee for Quality Assurance.

(3) STANDARD SETTING AND QUALIFICATION PROCESS FOR MEDICAL HOMES.—The Secretary

shall establish a process for the selection of a qualified standard setting and certification organization—

(A) to establish standards, consistent with this subsection, to enable medical practices to qualify as patient centered medical homes; and

(B) to provide for the review and certification of medical practices as meeting such standards.

(4) TREATMENT OF CERTAIN PRACTICES.—Nothing in this section shall be construed as preventing a nurse practitioner from leading a patient-centered medical home so long as—

(A) all of the requirements of this section are met; and

(B) the nurse practitioner is acting consistently with State law.

(e) APPLICATION UNDER MEDICARE, MEDICAID, PHSA, ETC.—Unless otherwise provided, the provisions of the previous subsections shall apply for purposes of provisions of the Social Security Act, the Public Health Service Act, and any other Act amended by this Act.

TITLE I—MEDICAL EDUCATION

SEC. 101. RECRUITMENT INCENTIVES.

Title VII of the Higher Education Act of 1965 (20 U.S.C. 1133 et seq.) is amended by adding at the end the following:

"PART F—MEDICAL EDUCATION RECRUITMENT INCENTIVES

"SEC. 786. MEDICAL EDUCATION RECRUITMENT INCENTIVES.

''(a) IN GENERAL.—The Secretary is authorized to award grants or contracts to institutions of higher education that are graduate medical schools, to enable the graduate medical schools to improve primary care education and training for medical students.

''(b) APPLICATION.—A graduate medical school that desires to receive a grant under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USES OF FUNDS.—A graduate medical school that receives a grant under this section shall use such grant funds to carry out 1 or more of the following:

''(1) The creation of primary care mentorship programs.

''(2) Curriculum development for population-based primary care models of care, such as the patient centered medical home.

''(3) Increased opportunities for ambulatory, community-based training.

''(4) Development of generalist curriculum to enhance care for rural and underserved populations in primary care or general surgery.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $50,000,000 for each of the fiscal years 2010 through 2012.''.

SEC. 102. DEBT FORGIVENESS, SCHOLARSHIPS, AND SERVICE OBLIGATIONS.

(a) PURPOSE.—It is the purpose of this section to encourage individuals to enter and continue in primary care physician careers.

(b) AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.—Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following:

''Subpart XI—Primary Care Medical Education

''SEC. 340I. SCHOLARSHIPS.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services

Administration, shall award grants to critical shortage health facilities to enable such facilities to provide scholarships to individuals who agree to serve as physicians at such facilities after completing a residency in a primary care field (as defined in section 3(a)(5) of the Preserving Patient Access to Primary Care Act of 2009).

''(b) SCHOLARSHIPS.—A health facility shall use amounts received under a grant under this section to enter into contracts with eligible individuals under which—

''(1) the facility agrees to provide the individual with a scholarship for each school year (not to exceed 4 school years) in which the individual is enrolled as a full-time student in a school of medicine or a school of osteopathic medicine; and

''(2) the individual agrees—

''(A) to maintain an acceptable level of academic standing;

''(B) to complete a residency in a primary care field; and

''(C) after completing the residency, to serve as a primary care physician at such facility in such field for a time period equal to the greater of—

"(i) one year for each school year for which the individual was provided a scholarship under this section; or

"(ii) two years.

"(c) AMOUNT.—

"(1) IN GENERAL.—The amount paid by a health facility to an individual under a scholarship under this section shall not exceed $35,000 for any school year.

"(2) CONSIDERATIONS.—In determining the amount of a scholarship to be provided to an individual under this section, a health facility may take into consideration the individual's financial need, geographic differences, and educational costs.

"(3) EXCLUSION FROM GROSS INCOME.—For purposes of the Internal Revenue Code of 1986, gross income shall not include any amount received as a scholarship under this section.

"(d) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subpart III of part D shall, except as inconsistent with this section, apply to the program established in subsection (a) in the same manner and to the same extent as such provisions apply to the National Health Service Corps Scholarship Program established in such subpart.

''(e) DEFINITIONS.—In this section:

''(1) CRITICAL SHORTAGE HEALTH FACILITY.—The term 'critical shortage health facility' means a public or private nonprofit health facility that does not serve a health professional shortage area (as designated under section 332), but has a critical shortage of physicians (as determined by the Secretary) in a primary care field.

''(2) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means an individual who is enrolled, or accepted for enrollment, as a full-time student in an accredited school of medicine or school of osteopathic medicine.

"SEC. 340J. LOAN REPAYMENT PROGRAM.

''(a) PURPOSE.—It is the purpose of this section to alleviate critical shortages of primary care physicians and primary care providers.

''(b) LOAN REPAYMENTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall establish a program of entering into contracts with eligible individuals under which—

''(1) the individual agrees to serve—

''(A) as a primary care physician or primary care provider in a primary care field; and

''(B) in an area that is not a health professional shortage area (as designated under section 332), but has a critical shortage of primary care physicians and primary care providers (as determined by the Secretary) in such field; and

''(2) the Secretary agrees to pay, for each year of such service, not more than $35,000 of the principal and interest of the undergraduate or graduate educational loans of the individual.

''(c) SERVICE REQUIREMENT.—A contract entered into under this section shall allow the individual receiving the loan repayment to satisfy the service requirement described in subsection (a)(1) through employment in a solo or group practice, a clinic, a public or private nonprofit hospital, or any other appropriate health care entity.

''(d) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subpart III of part D shall, except as inconsistent with this section, apply to the program established in subsection (a) in the same manner and to the same extent as such provisions apply to the National Health Service Corps Scholarship Program established in such subpart.

''(e) DEFINITION.—In this section, the term 'eligible individual' means—

''(1) an individual with a degree in medicine or osteopathic medicine; or

''(2) a primary care provider (as defined in section 3(a)(7) of the Preserving Patient Access to Primary Care Act of 2009).

''SEC. 340K. LOAN REPAYMENTS FOR PHYSICIANS IN THE FIELDS OF OBSTETRICS AND GYNECOLOGY AND CERTIFIED NURSE MIDWIVES.

''(a) PURPOSE.—It is the purpose of this section to alleviate critical shortages of physicians in the fields of obstetrics and gynecology and certified nurse midwives.

''(b) LOAN REPAYMENTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall establish a program of entering into contracts with eligible individuals under which—

''(1) the individual agrees to serve—

''(A) as a physician in the field of obstetrics and gynecology or as a certified nurse midwife; and

''(B) in an area that is not a health professional shortage area (as designated under section 332), but has a critical shortage of physicians in the fields of obstetrics and gynecology

or certified nurse midwives (as determined by the Secretary), respectively; and

''(2) the Secretary agrees to pay, for each year of such service, not more than $35,000 of the principal and interest of the undergraduate or graduate educational loans of the individual.

''(c) SERVICE REQUIREMENT.—A contract entered into under this section shall allow the individual receiving the loan repayment to satisfy the service requirement described in subsection (a)(1) through employment in a solo or group practice, a clinic, a public or private nonprofit hospital, or any other appropriate health care entity.

''(d) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subpart III of part D shall, except as inconsistent with this section, apply to the program established in subsection (a) in the same manner and to the same extent as such provisions apply to the National Health Service Corps Scholarship Program established in such subpart.

''(e) DEFINITION.—In this section, the term 'eligible individual' means—

''(1) a physician in the field of obstetrics and gynecology; or

''(2) a certified nurse midwife.

"SEC. 340L. REPORTS.

''Not later than 18 months after the date of enactment of this section, and annually thereafter, the Secretary shall submit to Congress a report that describes the programs carried out under this subpart, including statements concerning—

''(1) the number of enrollees, scholarships, loan repayments, and grant recipients;

''(2) the number of graduates;

''(3) the amount of scholarship payments and loan repayments made;

''(4) which educational institution the recipients attended;

''(5) the number and placement location of the scholarship and loan repayment recipients at health care facilities with a critical shortage of primary care physicians;

''(6) the default rate and actions required;

''(7) the amount of outstanding default funds of both the scholarship and loan repayment programs;

''(8) to the extent that it can be determined, the reason for the default;

''(9) the demographics of the individuals participating in the scholarship and loan repayment programs;

''(10) the justification for the allocation of funds between the scholarship and loan repayment programs; and

''(11) an evaluation of the overall costs and benefits of the programs.

''SEC. 340M. AUTHORIZATION OF APPROPRIATIONS.

''To carry out sections 340I, 340J, and 340K there are authorized to be appropriated $55,000,000 for fiscal year 2010, $90,000,000 for fiscal year 2011, and $125,000,000 for fiscal year 2012, to be used solely for scholarships and loan repayment awards for primary care physicians and primary care providers.''.

SEC. 103. DEFERMENT OF LOANS DURING RESIDENCY AND INTERNSHIPS.

(a) LOAN REQUIREMENTS.—Section 427(a)(2)(C)(i) of the Higher Education Act of 1965 (20 U.S.C. 1077(a)(2)(C)(i)) is amended by inserting ''unless the medical internship or residency program is in a primary care field (as defined in section 3(a)(5) of the Preserving Patient Access to Primary Care Act of 2009)'' after ''residency program''.

(b) FFEL LOANS.—Section 428(b)(1)(M)(i) of the Higher Education Act of 1965 (20 U.S.C. 1078(b)(1)(M)(i)) is amended by inserting ''unless the medical internship or residency program is in a primary

care field (as defined in section 3(a)(5) of the Preserving Patient Access to Primary Care Act of 2009)'' after ''residency program''.

(c) FEDERAL DIRECT LOANS.—Section 455(f)(2)(A) of the Higher Education Act of 1965 (20 U.S.C. 1087e(f)(2)(A)) is amended by inserting ''unless the medical internship or residency program is in a primary care field (as defined in section 3(a)(5) of the Preserving Patient Access to Primary Care Act of 2009)'' after ''residency program''.

(d) FEDERAL PERKINS LOANS.—Section 464(c)(2)(A)(i) of the Higher Education Act of 1965 (20 U.S.C. 1087dd(c)(2)(A)(i)) is amended by inserting ''unless the medical internship or residency program is in a primary care field (as defined in section 3(a)(5) of the Preserving Patient Access to Primary Care Act of 2009)'' after ''residency program''.

SEC. 104. EDUCATING MEDICAL STUDENTS ABOUT PRIMARY CARE CAREERS.

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

"SEC. 749. EDUCATING MEDICAL STUDENTS ABOUT PRIMARY CARE CAREERS.

''(a) IN GENERAL.—The Secretary shall award grants to eligible State and local government entities for the development of informational materials that promote careers in primary care by highlighting the advantages and rewards of primary care, and that encourage medical students, particularly students from disadvantaged backgrounds, to become primary care physicians.

''(b) ANNOUNCEMENT.—The grants described in subsection (a) shall be announced through a publication in the Federal Register and through appropriate media outlets in a manner intended to reach medical education institutions, associations, physician groups, and others who communicate with medical students.

''(c) ELIGIBILITY.—To be eligible to receive a grant under this section an entity shall—

''(1) be a State or local entity; and

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

''(d) USE OF FUNDS.—

''(1) IN GENERAL.—An entity shall use amounts received under a grant under this section to support State and local campaigns through appropriate media outlets to promote careers in primary

care and to encourage individuals from disadvantaged backgrounds to enter and pursue careers in primary care.

''(2) SPECIFIC USES.—In carrying out activities under paragraph (1), an entity shall use grants funds to develop informational materials in a manner intended to reach as wide and diverse an audience of medical students as possible, in order to—

''(A) advertise and promote careers in primary care;

''(B) promote primary care medical education programs;

''(C) inform the public of financial assistance regarding such education programs;

''(D) highlight individuals in the community who are practicing primary care physicians; or

''(E) provide any other information to recruit individuals for careers in primary care.

''(e) LIMITATION.—An entity shall not use amounts received under a grant under this section to advertise particular employment opportunities.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section,

such sums as may be necessary for each of fiscal years 2010 through 2013.''.

SEC. 105. TRAINING IN A FAMILY MEDICINE, GENERAL INTERNAL MEDICINE, GENERAL GERIATRICS, GENERAL PEDIATRICS, PHYSICIAN ASSISTANT EDUCATION, GENERAL DENTISTRY, AND PEDIATRIC DENTISTRY.

Section 747(e) of the Public Health Service Act (42 U.S.C. 293k) is amended by striking paragraph (1) and inserting the following:

''(1) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated $198,000,000 for each of fiscal years 2010 through 2012.''.

SEC. 106. INCREASED FUNDING FOR NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS.

(a) IN GENERAL.—There is authorized to be appropriated $332,000,000 for the period of fiscal years 2010 through 2012 for the purpose of carrying out subpart III of part D of title III of the Public Health Service Act (42 U.S.C. 254l et seq.). Such authorization of appropriations is in addition to the authorization of appropriations in section 338H of such Act (42 U.S.C. 254q) and any other authorization of appropriations for such purpose.

(b) ALLOCATION.—Of the amounts appropriated under subsection (a) for the period of fiscal years 2010 through 2012, the Secretary shall obligate $96,000,000 for the purpose of providing contracts for scholarships and loan repayments to individuals who—

(1) are primary care physicians or primary care providers; and

(2) have not previously received a scholarship or loan repayment under subpart III of part D of title III of the Public Health Service Act (42 U.S.C. 254l et seq.).

TITLE II—MEDICAID RELATED PROVISIONS

SEC. 201. TRANSFORMATION GRANTS TO SUPPORT PATIENT CENTERED MEDICAL HOMES UNDER MEDICAID AND CHIP.

(a) IN GENERAL.—Section 1903(z) of the Social Security Act (42 U.S.C. 1396b(z)) is amended—

(1) in paragraph (2), by adding at the end the following new subparagraph:

"(G) Methods for improving the effectiveness and efficiency of medical assistance provided under this title and child health assistance provided under title XXI by encouraging the adoption of medical practices that satisfy

the standards established by the Secretary under paragraph (2) of section 3(d) of the Preserving Patient Access to Primary Care Act of 2009 for medical practices to qualify as patient centered medical homes (as defined in paragraph (1) of such section).''; and

(2) in paragraph (4)—

(A) in subparagraph (A)—

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

(ii) in clause (ii), by striking the period at the end and inserting ''; and''; and

(iii) by inserting after clause (ii), the following new clause:

''(iii) $25,000,000 for each of fiscal years 2010, 2011, and 2012.''; and

(B) in subparagraph (B), by striking the second and third sentences and inserting the following: ''Such method shall provide that 100 percent of such funds for each of fiscal years 2010, 2011, and 2012 shall be allocated among States that design programs to adopt the innovative methods described in paragraph (2)(G), with preference given to States that design programs involving multipayers (including under

title XVIII and private health plans) test projects for implementation of the elements necessary to be recognized as a patient centered medical home practice under the National Committee for Quality Assurance Physicians Practice Connection-PCMH module (or any other equivalent process, as determined by the Secretary).''.

(b) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2010.

TITLE III—MEDICARE PROVISIONS

Subtitle A—Primary Care

SEC. 301. REFORMING PAYMENT SYSTEMS UNDER MEDICARE TO SUPPORT PRIMARY CARE.

(a) INCREASING BUDGET NEUTRALITY LIMITS UNDER THE PHYSICIAN FEE SCHEDULE TO ACCOUNT FOR ANTICIPATED SAVINGS RESULTING FROM PAYMENTS FOR CERTAIN SERVICES AND THE COORDINATION OF BENEFICIARY CARE.—Section 1848(c)(2)(B) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)) is amended—

(1) in clause (ii)(II), by striking ''(iv) and (v)'' and inserting ''(iv), (v), and (vii)''; and

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

''(vii) INCREASE IN LIMITATION TO ACCOUNT FOR CERTAIN ANTICIPATED SAVINGS.—

''(I) IN GENERAL.—Effective for fee schedules established beginning with 2010, the Secretary shall increase the limitation on annual adjustments under clause (ii)(II) by an amount equal to the anticipated savings under parts A, B, and D (including any savings with respect to items and services for which payment is not made under this section) which are a result of payments for designated primary care services and comprehensive care coordination services under section 1834(m) and the coverage of patient centered medical home services under section 1861(s)(2)(FF) (as determined by the Secretary).

''(II) MECHANISM TO DETERMINE APPLICATION OF INCREASE.—The Secretary shall establish a mechanism for determining which relative value units established under this

paragraph for physicians' services shall be subject to an adjustment under clause (ii)(I) as a result of the increase under subclause (I).

"(III) ADDITIONAL FUNDING AS DETERMINED NECESSARY BY THE SECRETARY.—In addition to any funding that may be made available as a result of an increase in the limitation on annual adjustments under subclause (I), there shall also be available to the Secretary, for purposes of making payments under this title for new services and capabilities to improve care provided to individuals under this title and to generate efficiencies under this title, such additional funds as the Secretary determines are necessary.".

(b) SEPARATE MEDICARE PAYMENT FOR DESIGNATED PRIMARY CARE SERVICES AND COMPREHENSIVE CARE COORDINATION SERVICES.—

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

''(n) PAYMENT FOR DESIGNATED PRIMARY CARE SERVICES AND COMPREHENSIVE CARE COORDINATION SERVICES.—

''(1) IN GENERAL.—The Secretary shall pay for designated primary care services and comprehensive care coordination services furnished to an individual enrolled under this part.

''(2) PAYMENT AMOUNT.—The Secretary shall determine the amount of payment for designated primary care services and comprehensive care coordination services under this subsection.

''(3) DOCUMENTATION REQUIREMENTS.—The Secretary shall propose appropriate documentation requirements to justify payments for designated primary care services and comprehensive care coordination services under this subsection.

''(4) DEFINITIONS.—

''(A) COMPREHENSIVE CARE COORDINATION SERVICES.—The term 'comprehensive care coordination services' means care coordination services with procedure codes established by the Secretary (as appropriate) which are furnished to an individual enrolled under this part by a primary care provider or principal care physician.

''(B) DESIGNATED PRIMARY CARE SERVICES.—The term 'designated primary care service' means a service which the Secretary determines has a procedure code which involves a clinical interaction with an individual enrolled under this part that is inherent to care coordination, including interactions outside of a face-to-face encounter. Such term includes the following:

''(i) Care plan oversight.

''(ii) Evaluation and management provided by phone.

''(iii) Evaluation and management provided using internet resources.

''(iv) Collection and review of physiologic data, such as from a remote monitoring device.

''(v) Education and training for patient self management.

''(vi) Anticoagulation management services.

''(vii) Any other service determined appropriate by the Secretary.''.

(2) EFFECTIVE DATE.—The amendment made by this section shall apply to items and services furnished on or after January 1, 2010.

SEC. 302. COVERAGE OF PATIENT CENTERED MEDICAL HOME SERVICES.

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

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

(2) in subparagraph (EE), by inserting ''and'' at the end; and

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

''(FF) patient centered medical home services (as defined in subsection (hhh)(1));''.

(b) DEFINITION OF PATIENT CENTERED MEDICAL HOME SERVICES.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Patient Centered Medical Home Services

''(hhh)(1) The term 'patient centered medical home services' means care coordination services furnished by a qualified patient centered medical home.

''(2) The term 'qualified patient centered medical home' means a patient centered medical home (as defined

in section 3(d) of the Preserving Patient Access to Primary Care Act of 2009).''.

(c) MONTHLY FEE FOR PATIENT CENTERED MEDICAL HOME SERVICES.—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) MONTHLY FEE FOR PATIENT CENTERED MEDICAL HOME SERVICES.—

''(1) MONTHLY FEE.—

''(A) IN GENERAL.—Not later than January 1, 2012, the Secretary shall establish a payment methodology for patient centered medical home services (as defined in paragraph (1) of section 1861(hhh)). Under such payment methodology, the Secretary shall pay qualified patient centered medical homes (as defined in paragraph (2) of such section) a monthly fee for each individual who elects to receive patient centered medical home services at that medical home. Such fee shall be paid on a prospective basis.

''(B) CONSIDERATIONS.—The Secretary shall take into account the results of the Medicare medical home demonstration project under section 204 of the Medicare Improvement and

Extension Act of 2006 (42 U.S.C. 1395b–1 note; division B of Public Law 109–432) in establishing the payment methodology under subparagraph (A).

''(2) AMOUNT OF PAYMENT.—

''(A) CONSIDERATIONS.—In determining the amount of such fee, subject to paragraph (3), the Secretary shall consider the following:

''(i) The clinical work and practice expenses involved in providing care coordination services consistent with the patient centered medical home model (such as providing increased access, care coordination, disease population management, and education) for which payment is not made under this section as of the date of enactment of this subsection.

''(ii) Ensuring that the amount of payment is sufficient to support the acquisition, use, and maintenance of clinical information systems which—

''(I) are needed by a qualified patient centered medical home; and

''(II) have been shown to facilitate improved outcomes through care coordination.

''(iii) The establishment of a tiered monthly care management fee that provides for a range of payment depending on how advanced the capabilities of a qualified patient centered medical home are in having the information systems needed to support care coordination.

''(B) RISK-ADJUSTMENT.—The Secretary shall use appropriate risk-adjustment in determining the amount of the monthly fee under this paragraph.

''(3) FUNDING.—

''(A) IN GENERAL.—The Secretary shall determine the aggregate estimated savings for a calendar year as a result of the implementation of this subsection on reducing preventable hospital admissions, duplicate testing, medication errors and drug interactions, and other savings under this part and part A (including any savings with respect to items and services for which payment is not made under this section).

"(B) FUNDING.—Subject to subparagraph (C), the aggregate amount available for payment of the monthly fee under this subsection during a calendar year shall be equal to the aggregate estimated savings (as determined under subparagraph (A)) for the calendar year (as determined by the Secretary).

"(C) ADDITIONAL FUNDING.—In the case where the amount of the aggregate actual savings during the preceding 3 years exceeds the amount of the aggregate estimated savings (as determined under subparagraph (A)) during such period, the aggregate amount available for payment of the monthly fee under this subsection during the calendar year (as determined under subparagraph (B)) shall be increased by the amount of such excess.

"(D) ADDITIONAL FUNDING AS DETERMINED NECESSARY BY THE SECRETARY.—In addition to any funding made available under subparagraphs (B) and (C), there shall also be available to the Secretary, for purposes of effectively implementing this subsection, such additional funds as the Secretary determines are necessary.

''(4) PERFORMANCE-BASED BONUS PAYMENTS.—The Secretary shall establish a process for paying a performance-based bonus to qualified patient centered medical homes which meet or achieve substantial improvements in performance (as specified under clinical, patient satisfaction, and efficiency benchmarks established by the Secretary). Such bonus shall be in an amount determined appropriate by the Secretary.

''(5) NO EFFECT ON PAYMENTS FOR EVALUATION AND MANAGEMENT SERVICES.—The monthly fee under this subsection shall have no effect on the amount of payment for evaluation and management services under this title.''.

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

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

(2) by inserting before the semicolon at the end the following: '', and (X) with respect to patient centered medical home services (as defined in section 1861(hhh)(1)), the amount paid shall be (i) in the case of such services which are physicians' services, the amount determined under subparagraph (N), and (ii) in the case of all other such services, 80 percent of the lesser of the actual charge for the service

or the amount determined under a fee schedule established by the Secretary for purposes of this subparagraph''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2012.

SEC. 303. MEDICARE PRIMARY CARE PAYMENT EQUITY AND ACCESS PROVISION.

(a) IN GENERAL.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as amended by section 302(c), is amended by adding at the end the following new subsection:

''(q) PRIMARY CARE PAYMENT EQUITY AND ACCESS.—

''(1) IN GENERAL.—Not later than January 1, 2010, the Secretary shall develop a methodology, in consultation with primary care physician organizations and primary care provider organizations, the Medicare Payment Advisory Commission, and other experts, to increase payments under this section for designated evaluation and management services provided by primary care physicians, primary care providers, and principal care providers through 1 or more of the following:

''(A) A service-specific modifier to the relative value units established for such services.

''(B) Service-specific bonus payments.

''(C) Any other methodology determined appropriate by the Secretary.

''(2) INCLUSION OF PROPOSED CRITERIA.—The methodology developed under paragraph (1) shall include proposed criteria for providers to qualify for such increased payments, including consideration of—

''(A) the type of service being rendered;

''(B) the specialty of the provider providing the service; and

''(C) demonstration by the provider of voluntary participation in programs to improve quality, such as participation in the Physician Quality Reporting Initiative (as determined by the Secretary) or practice-level qualification as a patient centered medical home.

''(3) FUNDING.—

''(A) DETERMINATION.—The Secretary shall determine the aggregate estimated savings for a calendar year as a result of such increased payments on reducing preventable hospital admissions, duplicate testing, medication errors

and drug interactions, Intensive Care Unit admissions, per capita health care expenditures, and other savings under this part and part A (including any savings with respect to items and services for which payment is not made under this section).

''(B) FUNDING.—The aggregate amount available for such increased payments during a calendar year shall be equal to the aggregate estimated savings (as determined under subparagraph (A)) for the calendar year (as determined by the Secretary).

''(C) ADDITIONAL FUNDING AS DETERMINED NECESSARY BY THE SECRETARY.—In addition to any funding made available under subparagraph (B), there shall also be available to the Secretary, for purposes of effectively implementing this subsection, such additional funds as the Secretary determines are necessary.''.

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

SEC. 304. ADDITIONAL INCENTIVE PAYMENT PROGRAM FOR PRIMARY CARE SERVICES FURNISHED IN HEALTH PROFESSIONAL SHORTAGE AREAS.

(a) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

''(x) ADDITIONAL INCENTIVE PAYMENTS FOR PRIMARY CARE SERVICES FURNISHED IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

''(1) IN GENERAL.—In the case of primary care services furnished on or after January 1, 2010, by a primary care physician or primary care provider in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area as identified by the Secretary prior to the beginning of the year involved, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

''(2) DEFINITIONS.—In this subsection:

''(A) PRIMARY CARE PHYSICIAN; PRIMARY CARE PROVIDER.—The terms 'primary care physician' and 'primary care provider' have the

meaning given such terms in paragraphs (6) and (7), respectively, of section 3(a) of the Preserving Patient Access to Primary Care Act of 2009.

''(B) PRIMARY CARE SERVICES.—The term 'primary care services' means procedure codes for services in the category of the Healthcare Common Procedure Coding System, as established by the Secretary under section 1848(c)(5) (as of December 31, 2008, and as subsequently modified by the Secretary) consisting of evaluation and management services, but limited to such procedure codes in the category of office or other outpatient services, and consisting of subcategories of such procedure codes for services for both new and established patients.

''(3) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting the identification of primary care physicians, primary care providers, or primary care services under this subsection.''.

(b) CONFORMING AMENDMENT.—Section 1834(g)(2)(B) of the Social Security Act (42 U.S.C. 1395m(g)(2)(B)) is amended by adding at the end the fol-

lowing sentence: ''Section 1833(x) shall not be taken into account in determining the amounts that would otherwise be paid pursuant to the preceding sentence.''.

SEC. 305. PERMANENT EXTENSION OF FLOOR ON MEDICARE WORK GEOGRAPHIC ADJUSTMENT UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(E)) is amended by striking ''and before January 1, 2010,''.

SEC. 306. PERMANENT EXTENSION OF MEDICARE INCENTIVE PAYMENT PROGRAM FOR PHYSICIAN SCARCITY AREAS.

Section 1833(u) of the Social Security Act (42 U.S.C. 1395l(u)) is amended—

(1) in paragraph (1)—

(A) by inserting ''or on or after July 1, 2009'' after ''before July 1, 2008''; and

(B) by inserting ''(or, in the case of services furnished on or after July 1, 2009, 10 percent)'' after ''5 percent''; and

(2) in paragraph (4)(D), by striking ''before July 1, 2008'' and inserting ''before January 1, 2010''.

SEC. 307. HHS STUDY AND REPORT ON THE PROCESS FOR DETERMINING RELATIVE VALUE UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

(a) STUDY.—The Secretary shall conduct a study on the process used by the Secretary for determining relative value under the Medicare physician fee schedule under section 1848(c) of the Social Security Act (42 U.S.C. 1395w–4(c)). Such study shall include an analysis of the following:

(1)(A) Whether the existing process includes equitable representation of primary care physicians (as defined in section 3(a)(6)); and

(B) any changes that may be necessary to ensure such equitable representation.

(2)(A) Whether the existing process provides the Secretary with expert and impartial input from physicians in medical specialties that provide primary care to patients with multiple chronic diseases, the fastest growing part of the Medicare population; and

(B) any changes that may be necessary to ensure such input.

(3)(A) Whether the existing process includes equitable representation of physician medical specialties in proportion to their relative contributions toward caring for Medicare beneficiaries, as deter-

mined by the percentage of Medicare billings per specialty, percentage of Medicare encounters by specialty, or such other measures of relative contributions to patient care as determined by the Secretary; and

(B) any changes that may be necessary to reflect such equitable representation.

(4)(A) Whether the existing process, including the application of budget neutrality rules, unfairly disadvantages primary care physicians, primary care providers, or other physicians who principally provide evaluation and management services; and

(B) any changes that may be necessary to eliminate such disadvantages.

(b) REPORT.—Not later than 12 months after the date of enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

Subtitle B—Preventive Services

SEC. 311. ELIMINATING TIME RESTRICTION FOR INITIAL PREVENTIVE PHYSICAL EXAMINATION.

(a) IN GENERAL.—Section 1862(a)(1)(K) of the Social Security Act (42 U.S.C. 1395y(a)(1)(K)) is amended

by striking ''more than'' and all that follows before the comma at the end and inserting ''more than one time during the lifetime of the individual''.

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

SEC. 312. ELIMINATION OF COST-SHARING FOR PREVENTIVE BENEFITS UNDER THE MEDICARE PROGRAM.

(a) DEFINITION OF PREVENTIVE SERVICES.—Section 1861(ddd) of the Social Security Act (42 U.S.C. 1395w(dd)) is amended—

(1) in the heading, by inserting ''; Preventive Services'' after ''Services'';

(2) in paragraph (1), by striking ''not otherwise described in this title'' and inserting ''not described in subparagraphs (A) through (N) of paragraph (3)''; and

(3) by adding at the end the following new paragraph:

''(3) The term 'preventive services' means the following:

''(A) Prostate cancer screening tests (as defined in subsection (oo)).

''(B) Colorectal cancer screening tests (as defined in subsection (pp)).

''(C) Diabetes outpatient self-management training services (as defined in subsection (qq)).

''(D) Screening for glaucoma for certain individuals (as described in subsection (s)(2)(U)).

''(E) Medical nutrition therapy services for certain individuals (as described in subsection (s)(2)(V)).

''(F) An initial preventive physical examination (as defined in subsection (ww)).

''(G) Cardiovascular screening blood tests (as defined in subsection (xx)(1)).

''(H) Diabetes screening tests (as defined in subsection (yy)).

''(I) Ultrasound screening for abdominal aortic aneurysm for certain individuals (as described in subsection (s)(2)(AA)).

''(J) Pneumococcal and influenza vaccine and their administration (as described in subsection (s)(10)(A)).

''(K) Hepatitis B vaccine and its administration for certain individuals (as described in subsection (s)(10)(B)).

''(L) Screening mammography (as defined in subsection (jj)).

''(M) Screening pap smear and screening pelvic exam (as described in subsection (s)(14)).

''(N) Bone mass measurement (as defined in subsection (rr)).

''(O) Additional preventive services (as determined under paragraph (1)).''.

(b) COINSURANCE.—

(1) GENERAL APPLICATION.—

(A) IN GENERAL.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by section 302, is amended—

(i) in subparagraph (T), by striking ''80 percent'' and inserting ''100 percent'';

(ii) in subparagraph (W), by striking ''80 percent'' and inserting ''100 percent'';

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

(iv) by inserting before the semicolon at the end the following: '', and (Y) with respect to preventive services described in subparagraphs (A) through (O) of section 1861(ddd)(3), the amount paid shall be

100 percent of the lesser of the actual charge for the services or the amount determined under the fee schedule that applies to such services under this part''.

(2) ELIMINATION OF COINSURANCE FOR SCREENING SIGMOIDOSCOPIES AND COLONOSCOPIES.—Section 1834(d) of the Social Security Act (42 U.S.C. 1395m(d)) is amended—

(A) in paragraph (2)—

(i) in subparagraph (A), by inserting '', except that payment for such tests under such section shall be 100 percent of the payment determined under such section for such tests'' before the period at the end; and

(ii) in subparagraph (C)—

(I) by striking clause (ii); and

(II) in clause (i)—

(aa) by striking ''(i) IN GENERAL.—Notwithstanding'' and inserting ''Notwithstanding'';

(bb) by redesignating subclauses (I) and (II) as clauses (i) and (ii), respectively, and moving

such clauses 2 ems to the left; and

(cc) in the flush matter following clause (ii), as so redesignated, by inserting ''100 percent of'' after ''based on''; and

(B) in paragraph (3)—

(i) in subparagraph (A), by inserting '', except that payment for such tests under such section shall be 100 percent of the payment determined under such section for such tests'' before the period at the end; and

(ii) in subparagraph (C)—

(I) by striking clause (ii); and

(II) in clause (i)—

(aa) by striking ''(i) IN GENERAL.—Notwithstanding'' and inserting ''Notwithstanding''; and

(bb) by inserting ''100 percent of'' after ''based on''.

(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, and preventive services (as defined in section 1861(ddd)(3))''.

(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'' after the semicolon at the end;

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

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

''(H) with respect to preventive services (as defined in section 1861(ddd)(3)) furnished by an outpatient department of a hospital, the amount determined under paragraph (1)(W) or (1)(X), as applicable;''.

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

(1) in clause (1), by striking ''items and services described in section 1861(s)(10)(A)'' and insert-

ing ''preventive services (as defined in section 1861(ddd)(3))'';

(2) by inserting ''and'' before ''(4)''; and

(3) by striking '', (5)'' and all that follows up to the period at the end.

SEC. 313. HHS STUDY AND REPORT ON FACILITATING THE RECEIPT OF MEDICARE PREVENTIVE SERVICES BY MEDICARE BENEFICIARIES.

(a) STUDY.—The Secretary, in consultation with provider organizations and other appropriate stakeholders, shall conduct a study on—

(1) ways to assist primary care physicians and primary care providers (as defined in section 3(a)) in—

(A) furnishing appropriate preventive services (as defined in section 1861(ddd)(3) of the Social Security Act, as added by section 312) to individuals enrolled under part B of title XVIII of such Act; and

(B) referring such individuals for other items and services furnished by other physicians and health care providers; and

(2) the advisability and feasability of making additional payments under the Medicare program to physicians and primary care providers for—

(A) the work involved in ensuring that such individuals receive appropriate preventive services furnished by other physicians and health care providers; and

(B) incorporating the resulting clinical information into the treatment plan for the individual.

(b) REPORT.—Not later than 12 months after the date of enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

Subtitle C—Other Provisions

SEC. 321. HHS STUDY AND REPORT ON IMPROVING THE ABILITY OF PHYSICIANS AND PRIMARY CARE PROVIDERS TO ASSIST MEDICARE BENEFICIARIES IN OBTAINING NEEDED PRESCRIPTIONS UNDER MEDICARE PART D.

(a) STUDY.—The Secretary, in consultation with physician organizations and other appropriate stakeholders, shall conduct a study on the development and implementation of mechanisms to facilitate increased efficiency relating to the role of physicians and primary care providers in Medicare beneficiaries obtaining needed prescription

drugs under the Medicare prescription drug program under part D of title XVIII of the Social Security Act. Such study shall include an analysis of ways to—

(1) improve the accessibility of formulary information;

(2) streamline the prior authorization, exception, and appeals processes, through, at a minimum, standardizing formats and allowing electronic exchange of information; and

(3) recognize the work of the physician and primary care provider involved in the prescribing process, especially work that may extend beyond the amount considered to be bundled into payment for evaluation and management services.

(b) REPORT.—Not later than 12 months after the date of enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

SEC. 322. HHS STUDY AND REPORT ON IMPROVED PATIENT CARE THROUGH INCREASED CAREGIVER AND PHYSICIAN INTERACTION.

(a) STUDY.—The Secretary, in consultation with appropriate stakeholders, shall conduct a study on the devel-

opment and implementation of mechanisms to promote and increase interaction between physicians or primary care providers and the families of Medicare beneficiaries, as well as other caregivers who support such beneficiaries, for the purpose of improving patient care under the Medicare program. Such study shall include an analysis of—

(1) ways to recognize the work of physicians and primary care providers involved in discussing clinical issues with caregivers that relate to the care of the beneficiary; and

(2) regulations under the Medicare program that are barriers to interactions between caregivers and physicians or primary care providers and how such regulations should be revised to eliminate such barriers.

(b) REPORT.—Not later than 12 months after the date of enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

SEC. 323. IMPROVED PATIENT CARE THROUGH EXPANDED SUPPORT FOR LIMITED ENGLISH PROFICIENCY (LEP) SERVICES.

(a) ADDITIONAL PAYMENTS FOR PRIMARY CARE PHYSICIANS AND PRIMARY CARE PROVIDERS.—Section 1833 of the Social Security Act (42 U.S.C. 1395l), as amended by section 304, is amended by adding at the end the following new subsection:

''(y) ADDITIONAL PAYMENTS FOR PROVIDING SERVICES TO INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY.—

''(1) IN GENERAL.—In the case of primary care providers' services furnished on or after January 1, 2010, to an individual with limited English proficiency by a provider, in addition to the amount of payment that would otherwise be made for such services under this part, there shall also be paid an appropriate amount (as determined by the Secretary) in order to recognize the additional time involved in furnishing the service to such individual.

''(2) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting the determination of the amount of additional payment under this subsection.''.

(b) NATIONAL CLEARINGHOUSE.—Not later than 180 days after the date of enactment of this Act, the Secretary shall establish a national clearinghouse to make available to the primary care physicians, primary care providers, patients, and States translated documents regarding patient care and education under the Medicare program, the Medicaid program, and the State Children's Health Insurance Program under titles XVIII, XIX, and XXI, respectively, of the Social Security Act.

(c) GRANTS TO SUPPORT LANGUAGE TRANSLATION SERVICES IN UNDERSERVED COMMUNITIES.—

(1) AUTHORITY TO AWARD GRANTS.—The Secretary shall award grants to support language translation services for primary care physicians and primary care providers in medically underserved areas (as defined in section 3(c)).

(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary to award grants under this subsection, such sums as are necessary for fiscal years beginning with fiscal year 2010.

SEC. 324. HHS STUDY AND REPORT ON USE OF REAL-TIME MEDICARE CLAIMS ADJUDICATION.

(a) STUDY.—The Secretary shall conduct a study to assess the ability of the Medicare program under title

XVIII of the Social Security Act to engage in real-time claims adjudication for items and services furnished to Medicare beneficiaries.

(b) CONSULTATION.—In conducting the study under subsection (a), the Secretary consult with stakeholders in the private sector, including stakeholders who are using or are testing real-time claims adjudication systems.

(c) REPORT.—Not later than January 1, 2011, the Secretary shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

SEC. 325. ONGOING ASSESSMENT BY MEDPAC OF THE IMPACT OF MEDICARE PAYMENTS ON PRIMARY CARE ACCESS AND EQUITY.

The Medicare Payment Advisory Commission, beginning in 2010 and in each of its subsequent annual reports to Congress on Medicare physician payment policies, shall provide an assessment of the impact of changes in Medicare payment policies in improving access to and equity of payments to primary care physicians and primary care providers. Such assessment shall include an assessment of the effectiveness, once implemented, of the Medicare payment-related reforms required by this Act to support pri-

mary care as well as any other payment changes that may be required by Congress to improve access to and equity of payments to primary care physicians and primary care providers.

SEC. 326. DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.

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

(1) in paragraph (4)(F)(i), by striking ''paragraph (7)'' and inserting ''paragraphs (7) and (8)'';

(2) in paragraph (4)(H)(i), by striking ''paragraph (7)'' and inserting ''paragraphs (7) and (8)''; and

(3) by adding at the end the following new paragraph:

''(8) DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.—

''(A) ADDITIONAL RESIDENCY POSITIONS.—

''(i) REDUCTION IN LIMIT BASED ON UNUSED POSITIONS.—

''(I) IN GENERAL.—The Secretary shall reduce the otherwise applicable resident limit for a hospital that the Secretary determines had

residency positions that were unused for all 5 of the most recent cost reporting periods ending prior to the date of enactment of this paragraph by an amount that is equal to the number of such unused residency positions.

''(II) EXCEPTION FOR RURAL HOSPITALS AND CERTAIN OTHER HOSPITALS.—This subparagraph shall not apply to a hospital—

''(aa) located in a rural area (as defined in subsection (d)(2)(D)(ii));

''(bb) that has participated in a voluntary reduction plan under paragraph (6); or

''(cc) that has participated in a demonstration project approved as of October 31, 2003, under the authority of section 402 of Public Law 90–248.

''(ii) NUMBER AVAILABLE FOR DISTRIBUTION.—The number of additional residency positions available for distribu-

tion under subparagraph (B) shall be an amount that the Secretary determines would result in a 15 percent increase in the aggregate number of full-time equivalent residents in approved medical training programs (as determined based on the most recent cost reports available at the time of distribution). One-third of such number shall only be available for distribution to hospitals described in subclause (I) of subparagraph (B)(ii) under such subparagraph.

''(B) DISTRIBUTION.—

''(i) IN GENERAL.—The Secretary shall increase the otherwise applicable resident limit for each qualifying hospital that submits an application under this subparagraph by such number as the Secretary may approve for portions of cost reporting periods occurring on or after the date of enactment of this paragraph. The aggregate number of increases in the otherwise applicable resident limit under this subparagraph shall be equal to the number of

additional residency positions available for distribution under subparagraph (A)(ii).

"(ii) DISTRIBUTION TO HOSPITALS ALREADY OPERATING OVER RESIDENT LIMIT.—

"(I) IN GENERAL.—Subject to subclause (II), in the case of a hospital in which the reference resident level of the hospital (as defined in clause (ii)) is greater than the otherwise applicable resident limit, the increase in the otherwise applicable resident limit under this subparagraph shall be an amount equal to the product of the total number of additional residency positions available for distribution under subparagraph (A)(ii) and the quotient of—

"(aa) the number of resident positions by which the reference resident level of the hospital exceeds the otherwise applicable resident limit for the hospital; and

''(bb) the number of resident positions by which the reference resident level of all such hospitals with respect to which an application is approved under this subparagraph exceeds the otherwise applicable resident limit for such hospitals.

''(II) REQUIREMENTS.—A hospital described in subclause (I)—

''(aa) is not eligible for an increase in the otherwise applicable resident limit under this subparagraph unless the amount by which the reference resident level of the hospital exceeds the otherwise applicable resident limit is not less than 10 and the hospital trains at least 25 percent of the full-time equivalent residents of the hospital in primary care and general surgery (as of the date of enactment of this paragraph); and

"(bb) shall continue to train at least 25 percent of the full-time equivalent residents of the hospital in primary care and general surgery for the 10-year period beginning on such date.

In the case where the Secretary determines that a hospital no longer meets the requirement of item (bb), the Secretary may reduce the otherwise applicable resident limit of the hospital by the amount by which such limit was increased under this clause.

"(III) CLARIFICATION REGARDING ELIGIBILITY FOR OTHER ADDITIONAL RESIDENCY POSITIONS.—Nothing in this clause shall be construed as preventing a hospital described in subclause (I) from applying for additional residency positions under this paragraph that are not reserved for distribution under this clause.

"(iii) REFERENCE RESIDENT LEVEL.—

''(I) IN GENERAL.—Except as otherwise provided in subclause (II), the reference resident level specified in this clause for a hospital is the resident level for the most recent cost reporting period of the hospital ending on or before the date of enactment of this paragraph, for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

''(II) USE OF MOST RECENT ACCOUNTING PERIOD TO RECOGNIZE EXPANSION OF EXISTING PROGRAM OR ESTABLISHMENT OF NEW PROGRAM.—If a hospital submits a timely request to increase its resident level due to an expansion of an existing residency training program or the establishment of a new residency training program that is not reflected on the most recent cost report that has been settled (or, if not, submitted (subject to audit)), after audit and subject to the discretion of the Sec-

retary, the reference resident level for such hospital is the resident level for the cost reporting period that includes the additional residents attributable to such expansion or establishment, as determined by the Secretary.

''(C) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B) (other than an increase under subparagraph (B)(ii)), the Secretary shall take into account the demonstrated likelihood of the hospital filling the positions within the first 3 cost reporting periods beginning on or after July 1, 2010, made available under this paragraph, as determined by the Secretary.

''(D) PRIORITY FOR CERTAIN AREAS.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B) (other than an increase under subparagraph (B)(ii)), the Secretary shall distribute the increase to hospitals based on the following criteria:

''(i) The Secretary shall give preference to hospitals that submit applications for new primary care and general surgery residency positions. In the case of any increase based on such preference, a hospital shall ensure that—

''(I) the position made available as a result of such increase remains a primary care or general surgery residency position for not less than 10 years after the date on which the position is filled; and

''(II) the total number of primary care and general surgery residency positions in the hospital (determined based on the number of such positions as of the date of such increase, including any position added as a result of such increase) is not decreased during such 10-year period.

In the case where the Secretary determines that a hospital no longer meets the requirement of subclause (II), the Secretary may reduce the otherwise applicable resident limit of the hospital by the amount by

which such limit was increased under this paragraph.

''(ii) The Secretary shall give preference to hospitals that emphasizes training in community health centers and other community-based clinical settings.

''(iii) The Secretary shall give preference to hospitals in States that have more medical students than residency positions available (including a greater preference for those States with smaller resident-to-medical-student ratios). In determining the number of medical students in a State for purposes of the preceding sentence, the Secretary shall include planned students at medical schools which have provisional accreditation by the Liaison Committee on Medical Education or the American Osteopathic Association.

''(iv) The Secretary shall give preference to hospitals in States that have low resident-to-population ratios (including a greater preference for those States with lower resident-to-population ratios).

''(E) LIMITATION.—

"(i) IN GENERAL.—Except as provided in clause (ii), in no case may a hospital (other than a hospital described in subparagraph (B)(ii)(I), subject to the limitation under subparagraph (B)(ii)(III)) apply for more than 50 full-time equivalent additional residency positions under this paragraph.

"(ii) INCREASE IN NUMBER OF ADDITIONAL POSITIONS AVAILABLE FOR DISTRIBUTION.—The Secretary shall increase the number of full-time equivalent additional residency positions a hospital may apply for under this paragraph if the Secretary determines that the number of additional residency positions available for distribution under subparagraph (A)(ii) exceeds the number of such applications approved.

"(F) APPLICATION OF PER RESIDENT AMOUNTS FOR PRIMARY CARE AND NONPRIMARY CARE.—With respect to additional residency positions in a hospital attributable to the increase provided under this paragraph, the approved FTE resident amounts are deemed to be

equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital.

''(G) DISTRIBUTION.—The Secretary shall distribute the increase to hospitals under this paragraph not later than 2 years after the date of enactment of this paragraph.''.

(b) IME.—

(1) IN GENERAL.—Section 1886(d)(5)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the second sentence, is amended—

(A) by striking ''subsection (h)(7)'' and inserting ''subsections (h)(7) and (h)(8)''; and

(B) by striking ''it applies'' and inserting ''they apply''.

(2) CONFORMING PROVISION.—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 clause:

''(x) For discharges occurring on or after the date of enactment of this clause, insofar as an additional payment amount under this subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(8)(B), the indirect

teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.''.

SEC. 327. COUNTING RESIDENT TIME IN OUTPATIENT SETTINGS.

(a) D–GME.—Section 1886(h)(4)(E) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(E)) is amended—

(1) by striking ''under an approved medical residency training program''; and

(2) by striking ''if the hospital incurs all, or substantially all, of the costs for the training program in that setting'' and inserting ''if the hospital continues to incur the costs of the stipends and fringe benefits of the resident during the time the resident spends in that setting''.

(b) IME.—Section 1886(d)(5)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amended—

(1) by striking ''under an approved medical residency training program''; and

(2) by striking ''if the hospital incurs all, or substantially all, of the costs for the training program in that setting'' and inserting ''if the hospital continues to incur the costs of the stipends and

fringe benefits of the intern or resident during the time the intern or resident spends in that setting''.

(c) EFFECTIVE DATES; APPLICATION.—

(1) IN GENERAL.—Effective for cost reporting periods beginning on or after July 1, 2009, the Secretary of Health and Human Services shall implement the amendments made by this section in a manner so as to apply to cost reporting periods beginning on or after July 1, 2009.

(2) APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. 1395ww(h)).

SEC. 328. RULES FOR COUNTING RESIDENT TIME FOR DIDACTIC AND SCHOLARLY ACTIVITIES AND OTHER ACTIVITIES.

(a) GME.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)), as amended by section 327(a), is amended—

(1) in paragraph (4)(E)—

(A) by designating the first sentence as a clause (i) with the heading ''IN GENERAL'' and appropriate indentation and by striking ''Such rules'' and inserting ''Subject to clause (ii), such rules''; and

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

''(ii) TREATMENT OF CERTAIN NONHOSPITAL AND DIDACTIC ACTIVITIES.—Such rules shall provide that all time spent by an intern or resident in an approved medical residency training program in a nonhospital setting that is primarily engaged in furnishing patient care (as defined in paragraph (5)(K)) in non-patient care activities, such as didactic conferences and seminars, but not including research not associated with the treatment or diagnosis of a particular patient, as such time

and activities are defined by the Secretary, shall be counted toward the determination of full-time equivalency.'';

(2) in paragraph (4), by adding at the end the following new subparagraph:

''(I) In determining the hospital's number of full-time equivalent residents for purposes of this subsection, all the time that is spent by an intern or resident in an approved medical residency training program on vacation, sick leave, or other approved leave, as such time is defined by the Secretary, and that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program shall be counted toward the determination of full-time equivalency.''; and

(3) in paragraph (5), by adding at the end the following new subparagraph:

''(M) NONHOSPITAL SETTING THAT IS PRIMARILY ENGAGED IN FURNISHING PATIENT CARE.—The term 'nonhospital setting that is primarily engaged in furnishing patient care' means a nonhospital setting in which the primary activity is the care and treatment of patients, as defined by the Secretary.''.

(b) IME DETERMINATIONS.—Section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B)), as amended by section 326(b), is amended by adding at the end the following new clause:

''(xi)(I) The provisions of subparagraph (I) of subsection (h)(4) shall apply under this subparagraph in the same manner as they apply under such subsection.

''(II) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in non-patient care activities, such as didactic conferences and seminars, as such time and activities are defined by the Secretary, that occurs in the hospital shall be counted toward the determination of full-time equivalency if the hospital—

''(aa) is recognized as a subsection (d) hospital;

''(bb) is recognized as a subsection (d) Puerto Rico hospital;

''(cc) is reimbursed under a reimbursement system authorized under section 1814(b)(3); or

''(dd) is a provider-based hospital outpatient department.

''(III) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in research activities that are not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall not be counted toward the determination of full-time equivalency.''.

(c) EFFECTIVE DATES; APPLICATION.—

(1) IN GENERAL.—Except as otherwise provided, the Secretary of Health and Human Services shall implement the amendments made by this section in a manner so as to apply to cost reporting periods beginning on or after January 1, 1983.

(2) DIRECT GME.—Section 1886(h)(4)(E)(ii) of the Social Security Act, as added by subsection (a)(1)(B), shall apply to cost reporting periods beginning on or after July 1, 2009.

(3) IME.—Section 1886(d)(5)(B)(xi)(III) of the Social Security Act, as added by subsection (b), shall apply to cost reporting periods beginning on or after October 1, 2001. Such section, as so added, shall not give rise to any inference on how the law in effect prior to such date should be interpreted.

(4) APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act or for direct graduate medical education costs under section 1886(h) of such Act.

SEC. 329. PRESERVATION OF RESIDENT CAP POSITIONS FROM CLOSED AND ACQUIRED HOSPITALS.

(a) GME.—Section 1886(h)(4)(H) of the Social Security Act (42 U.S.C. Section 1395ww(h)(4)(H)) is amended by adding at the end the following new clauses:

"(vi) REDISTRIBUTION OF RESIDENCY SLOTS AFTER A HOSPITAL CLOSES.—

"(I) IN GENERAL.—Subject to the succeeding provisions of this clause, the Secretary shall, by regulation, establish a process under which, in the case where a hospital with an approved medical residency program closes on or after the date of enactment of the Balanced Budget Act of

1997, the Secretary shall increase the otherwise applicable resident limit under this paragraph for other hospitals in accordance with this clause.

''(II) PRIORITY FOR HOSPITALS IN CERTAIN AREAS.—Subject to the succeeding provisions of this clause, in determining for which hospitals the increase in the otherwise applicable resident limit is provided under such process, the Secretary shall distribute the increase to hospitals located in the following priority order (with preference given within each category to hospitals that are members of the same affiliated group (as defined by the Secretary under clause (ii)) as the closed hospital):

''(aa) First, to hospitals located in the same core-based statistical area as, or a core-based statistical area contiguous to, the hospital that closed.

"(bb) Second, to hospitals located in the same State as the hospital that closed.

"(cc) Third, to hospitals located in the same region of the country as the hospital that closed.

"(dd) Fourth, to all other hospitals.

"(III) REQUIREMENT HOSPITAL LIKELY TO FILL POSITION WITHIN CERTAIN TIME PERIOD.—The Secretary may only increase the otherwise applicable resident limit of a hospital under such process if the Secretary determines the hospital has demonstrated a likelihood of filling the positions made available under this clause within 3 years.

"(IV) LIMITATION.—The aggregate number of increases in the otherwise applicable resident limits for hospitals under this clause shall be equal to the number of resident positions in the approved medical residency pro-

grams that closed on or after the date described in subclause (I).

''(vii) SPECIAL RULE FOR ACQUIRED HOSPITALS.—

''(I) IN GENERAL.—In the case of a hospital that is acquired (through any mechanism) by another entity with the approval of a bankruptcy court, during a period determined by the Secretary (but not less than 3 years), the applicable resident limit of the acquired hospital shall, except as provided in subclause (II), be the applicable resident limit of the hospital that was acquired (as of the date immediately before the acquisition), without regard to whether the acquiring entity accepts assignment of the Medicare provider agreement of the hospital that was acquired, so long as the acquiring entity continues to operate the hospital that was acquired and to furnish services, medical residency programs, and volume of patients similar to the services, medical resi-

dency programs, and volume of patients of the hospital that was acquired (as determined by the Secretary) during such period.

''(II) LIMITATION.—Subclause (I) shall only apply in the case where an acquiring entity waives the right as a new provider under the program under this title to have the otherwise applicable resident limit of the acquired hospital re-established or increased.''.

(b) IME.—Section 1886(d)(5)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the second sentence, as amended by section 326(b), is amended by striking ''subsections (h)(7) and (h)(8)'' and inserting ''subsections (h)(4)(H)(vi), (h)(4)(H)(vii), (h)(7), and (h)(8)''.

(c) APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C.

1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. 1395ww(h)).

(d) NO AFFECT ON TEMPORARY FTE CAP ADJUSTMENTS.—The amendments made by this section shall not affect any temporary adjustment to a hospital's FTE cap under section 413.79(h) of title 42, Code of Federal Regulations (as in effect on the date of enactment of this Act).

SEC. 330. QUALITY IMPROVEMENT ORGANIZATION ASSISTANCE FOR PHYSICIAN PRACTICES SEEKING TO BE PATIENT CENTERED MEDICAL HOME PRACTICES.

Not later than 90 days after the date of enactment of this Act, the Secretary of Health and Human Services shall revise the 9th Statement of Work under the Quality Improvement Program under part B of title XI of the Social Security Act to include a requirement that, in order to be an eligible Quality Improvement Organization (in this section referred to as a ''QIO'') for the 9th Statement of Work contract cycle, a QIO shall provide assistance, including technical assistance, to physicians under the Medicare program under title XVIII of the Social Security Act that seek to acquire the elements necessary to be recognized as a patient centered medical home practice under the National Committee for Quality Assurance's Physician

Practice Connections-PCMH module (or any successor module issued by such Committee).

TITLE IV—STUDIES

SEC. 401. STUDY CONCERNING THE DESIGNATION OF PRIMARY CARE AS A SHORTAGE PROFESSION.

(a) IN GENERAL.—Not later than June 30, 2010, the Secretary of Labor shall conduct a study and submit to the Committee on Education and Labor of the House of Representatives and the Committee on Health, Education, Labor, and Pensions a report that contains—

(1) a description of the criteria for the designation of primary care physicians as professions in shortage as defined by the Secretary under section 212(a)(5)(A) of the Immigration and Nationality Act;

(2) the findings of the Secretary on whether primary care physician professions will, on the date on which the report is submitted, or within the 5-year period beginning on such date, satisfy the criteria referred to in paragraph (1); and

(3) if the Secretary finds that such professions will not satisfy such criteria, recommendations for modifications to such criteria to enable primary care physicians to be so designated as a profession in shortage.

(b) REQUIREMENTS.—In conducting the study under subsection (a), the Secretary of Labor shall consider workforce data from the Health Resources and Services Administration, the Council on Graduate Medical Education, the Association of American Medical Colleges, and input from physician membership organizations that represent primary care physicians.

SEC. 402. STUDY CONCERNING THE EDUCATION DEBT OF MEDICAL SCHOOL GRADUATES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study to evaluate the higher education-related indebtedness of medical school graduates in the United States at the time of graduation from medical school, and the impact of such indebtedness on specialty choice, including the impact on the field of primary care.

(b) REPORT.—

(1) SUBMISSION AND DISSEMINATION OF REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General shall submit a report on the study required by subsection (a) to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Education and Labor of the House of Representatives, and shall make such report widely available to the public.

(2) ADDITIONAL REPORTS.—The Comptroller General may periodically prepare and release as necessary additional reports on the topic described in subsection (a).

SEC. 403. STUDY ON MINORITY REPRESENTATION IN PRIMARY CARE.

(a) STUDY.—The Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration, shall conduct a study of minority representation in training, and in practice, in primary care specialties.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration, shall submit to the appropriate committees of Congress a report concerning the study conducted under subsection (a), including recommendations for achieving a primary care workforce that is more representative of the population of the United States.

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