

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

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.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Preserving Patient Access to Primary Care Act of 2009”.

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

- Sec. 1. Short title; table of contents.
- Sec. 2. Findings.
- Sec. 3. Definitions.

TITLE I—MEDICAL EDUCATION

- Sec. 101. Recruitment incentives.
- Sec. 102. Debt forgiveness, scholarships, and service obligations.
- Sec. 103. Deferment of loans during residency and internships.
- Sec. 104. Educating medical students about primary care careers.
- Sec. 105. Training in a family medicine, general internal medicine, general geriatrics, general pediatrics, physician assistant education, general dentistry, and pediatric dentistry.
- Sec. 106. Increased funding for National Health Service Corps Scholarship and Loan Repayment Programs.

TITLE II—MEDICAID RELATED PROVISIONS

- Sec. 201. Transformation grants to support patient centered medical homes under Medicaid and CHIP.

TITLE III—MEDICARE PROVISIONS

Subtitle A—Primary Care

- Sec. 301. Reforming payment systems under Medicare to support primary care.
- Sec. 302. Coverage of patient centered medical home services.
- Sec. 303. Medicare primary care payment equity and access provision.
- Sec. 304. Additional incentive payment program for primary care services furnished in health professional shortage areas.
- Sec. 305. Permanent extension of floor on Medicare work geographic adjustment under the Medicare physician fee schedule.
- Sec. 306. Permanent extension of Medicare incentive payment program for physician scarcity areas.
- Sec. 307. HHS study and report on the process for determining relative value under the Medicare physician fee schedule.

Subtitle B—Preventive Services

- Sec. 311. Eliminating time restriction for initial preventive physical examination.
- Sec. 312. Elimination of cost-sharing for preventive benefits under the Medicare program.
- Sec. 313. HHS study and report on facilitating the receipt of Medicare preventive services by Medicare beneficiaries.

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.
- Sec. 322. HHS study and report on improved patient care through increased caregiver and physician interaction.
- Sec. 323. Improved patient care through expanded support for limited English proficiency (LEP) services.
- Sec. 324. HHS study and report on use of real-time Medicare claims adjudication.

- Sec. 325. Ongoing assessment by MedPAC of the impact of medicare payments on primary care access and equity.
- Sec. 326. Distribution of additional residency positions.
- Sec. 327. Counting resident time in outpatient settings.
- Sec. 328. Rules for counting resident time for didactic and scholarly activities and other activities.
- Sec. 329. Preservation of resident cap positions from closed and acquired hospitals.
- Sec. 330. Quality improvement organization assistance for physician practices seeking to be patient centered medical home practices.

TITLE IV—STUDIES

- Sec. 401. Study concerning the designation of primary care as a shortage profession.
- Sec. 402. Study concerning the education debt of medical school graduates.
- Sec. 403. Study on minority representation in primary care.

1 **SEC. 2. FINDINGS.**

2 Congress makes the following findings:

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

9 (2) The number of United States medical grad-
 10 uates going into family medicine has fallen by more
 11 than 50 percent from 1997 to 2005.

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

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

1 general internal medicine, down from 54 percent in
2 1998.

3 (5) Primary care physicians serve as the point
4 of first contact for most patients and are able to co-
5 ordinate the care of the whole person, reducing un-
6 necessary care and duplicative testing.

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

12 (7) Patients with primary care physicians or
13 primary care providers have lower health care ex-
14 penditures and primary care is correlated with better
15 health status, lower overall mortality, and longer life
16 expectancy.

17 (8) Higher proportions of primary care physi-
18 cians are associated with significantly reduced utili-
19 zation.

20 (9) The United States has a higher ratio of spe-
21 cialists to primary care physicians than other indus-
22 trialized nations and the population of the United
23 States is growing faster than the expected rate of
24 growth in the supply of primary care physicians.

1 (10) The number of Americans age 65 and
2 older, those eligible for Medicare and who use far
3 more ambulatory care visits per person as those
4 under age 65, is expected to double from 2000 to
5 2030.

6 (11) A decrease in Federal spending to carry
7 out programs authorized by title VII of the Public
8 Health Service Act threatens the viability of one of
9 the programs used to solve the problem of inad-
10 equate access to primary care.

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

16 (13) Individuals in many geographic areas, es-
17 pecially rural areas, lack adequate access to high
18 quality preventive, primary health care, contributing
19 to significant health disparities that impair Amer-
20 ica's public health and economic productivity.

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

24 **SEC. 3. DEFINITIONS.**

25 (a) GENERAL DEFINITIONS.—In this Act:

1 (1) CHRONIC CARE COORDINATION.—The term
2 “chronic care coordination” means the coordination
3 of services that is based on the Chronic Care Model
4 that provides on-going health care to patients with
5 chronic diseases that may include any of the fol-
6 lowing services:

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

10 (B) The management of, and referral for,
11 medical and other health services, including
12 interdisciplinary care conferences and manage-
13 ment with other providers.

14 (C) The monitoring and management of
15 medications.

16 (D) Patient education and counseling serv-
17 ices.

18 (E) Family caregiver education and coun-
19 seling services.

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

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

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

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

5 (I) Managing and facilitating transitions
6 among health care professionals and across set-
7 tings of care, including the following:

8 (i) Pursuing the treatment option
9 elected by the individual.

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

13 (J) Information about, and referral to,
14 hospice care, including patient and family care-
15 giver education and counseling about hospice
16 care, and facilitating transition to hospice care
17 when elected.

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

20 (2) CRITICAL SHORTAGE HEALTH FACILITY.—

21 The term “critical shortage health facility” means a
22 public or private nonprofit health facility that does
23 not serve a health professional shortage area (as
24 designated under section 332 of the Public Health
25 Service Act), but that has a critical shortage of phy-

1 sicians (as determined by the Secretary) in a pri-
2 mary care field.

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

6 (4) PRIMARY CARE.—The term “primary care”
7 means the provision of integrated, high-quality, ac-
8 cessible health care services by health care providers
9 who are accountable for addressing a full range of
10 personal health and health care needs, developing a
11 sustained partnership with patients, practicing in
12 the context of family and community, and working
13 to minimize disparities across population subgroups.

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

16 (A) The field of family medicine.

17 (B) The field of general internal medicine.

18 (C) The field of geriatric medicine.

19 (D) The field of pediatric medicine

20 (6) PRIMARY CARE PHYSICIAN.—The term “pri-
21 mary care physician” means a physician who is
22 trained in a primary care field who provides first
23 contact, continuous, and comprehensive care to pa-
24 tients.

1 (7) PRIMARY CARE PROVIDER.—The term “pri-
2 mary care provider” means—

3 (A) a nurse practitioner; or

4 (B) a physician assistant practicing as a
5 member of a physician-directed team;
6 who provides first contact, continuous, and com-
7 prehensive care to patients.

8 (8) PRINCIPAL CARE.—The term “principal
9 care” means integrated, accessible health care that
10 is provided by a physician who is a medical sub-
11 specialist that addresses the majority of the personal
12 health care needs of patients with chronic conditions
13 requiring the subspecialist’s expertise, and for whom
14 the subspecialist assumes care management, devel-
15 oping a sustained physician-patient partnership and
16 practicing within the context of family and commu-
17 nity.

18 (9) SECRETARY.—The term “Secretary” means
19 the Secretary of Health and Human Services.

20 (b) PRIMARY MEDICAL CARE SHORTAGE AREA.—

21 (1) IN GENERAL.—In this Act, the term “pri-
22 mary medical care shortage area” or “PMCSA”
23 means a geographic area with a shortage of physi-
24 cians (as designated by the Secretary) in a primary

1 care field, as designated in accordance with para-
2 graph (2).

3 (2) DESIGNATION.—To be designated by the
4 Secretary as a PMCSA, the Secretary must find
5 that the geographic area involved has an established
6 shortage of primary care physicians for the popu-
7 lation served. The Secretary shall make such a des-
8 ignation with respect to an urban or rural geo-
9 graphic area if the following criteria are met:

10 (A) The area is a rational area for the de-
11 livery of primary care services.

12 (B) One of the following conditions pre-
13 vails within the area:

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

17 (ii) The area has a population to full-
18 time-equivalent primary care physician
19 ratio of less than 3,500 to 1 and has un-
20 usually high needs for primary care serv-
21 ices or insufficient capacity of existing pri-
22 mary care providers.

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

25 (c) MEDICALLY UNDERSERVED AREA.—

1 (1) IN GENERAL.—In this Act, the term “medi-
2 cally underserved area” or “MUA” means a rational
3 service area with a demonstrable shortage of pri-
4 mary health care resources relative to the needs of
5 the entire population within the service area as de-
6 termined in accordance with paragraph (2) through
7 the use of the Index of Medical Underservice (re-
8 ferred to in this subsection as the “IMU”) with re-
9 spect to data on a service area.

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

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

18 (A) The ratio of primary medical care phy-
19 sicians per 1,000 individuals in the population
20 of the area involved.

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

23 (C) The percentage of the population in-
24 volved with incomes below the poverty level.

1 (D) The percentage of the population in-
2 volved age 65 or over.

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

7 (d) PATIENT CENTERED MEDICAL HOME.—

8 (1) IN GENERAL.—In this Act, the term “pa-
9 tient centered medical home” means a physician-di-
10 rected practice (or a nurse practitioner-directed
11 practice in those States in which such functions are
12 included in the scope of practice of licensed nurse
13 practitioners) that has been certified by an organiza-
14 tion under paragraph (3) as meeting the following
15 standards:

16 (A) The practice provides patients who
17 elect to obtain care through a patient centered
18 medical home (referred to as “participating pa-
19 tients”) with direct and ongoing access to a pri-
20 mary or principal care physician or a primary
21 care provider who accepts responsibility for pro-
22 viding first contact, continuous, and comprehen-
23 sive care to the whole person, in collaboration
24 with teams of other health professionals, includ-

1 ing nurses and specialist physicians, as needed
2 and appropriate.

3 (B) The practice applies standards for ac-
4 cess to care and communication with partici-
5 pating beneficiaries.

6 (C) The practice has readily accessible,
7 clinically useful information on participating pa-
8 tients that enables the practice to treat such
9 patients comprehensively and systematically.

10 (D) The practice maintains continuous re-
11 lationships with participating patients by imple-
12 menting evidence-based guidelines and applying
13 such guidelines to the identified needs of indi-
14 vidual beneficiaries over time and with the in-
15 tensity needed by such beneficiaries.

16 (2) RECOGNITION OF NCQA APPROVAL.—Such
17 term also includes a physician-directed (or nurse-
18 practitioner-directed) practice that has been recog-
19 nized as a medical home through the Physician
20 Practice Connections—patient centered Medical
21 Home (“PPC–PCMH”) voluntary recognition proc-
22 ess of the National Committee for Quality Assur-
23 ance.

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

1 shall establish a process for the selection of a quali-
2 fied standard setting and certification organiza-
3 tion—

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

7 (B) to provide for the review and certifi-
8 cation of medical practices as meeting such
9 standards.

10 (4) TREATMENT OF CERTAIN PRACTICES.—

11 Nothing in this section shall be construed as pre-
12 venting a nurse practitioner from leading a patient-
13 centered medical home so long as—

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

16 (B) the nurse practitioner is acting con-
17 sistently with State law.

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

1 **TITLE I—MEDICAL EDUCATION**

2 **SEC. 101. RECRUITMENT INCENTIVES.**

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

6 **“PART F—MEDICAL EDUCATION RECRUITMENT**
7 **INCENTIVES**

8 **“SEC. 786. MEDICAL EDUCATION RECRUITMENT INCEN-**
9 **TIVES.**

10 “(a) IN GENERAL.—The Secretary is authorized to
11 award grants or contracts to institutions of higher edu-
12 cation that are graduate medical schools, to enable the
13 graduate medical schools to improve primary care edu-
14 cation and training for medical students.

15 “(b) APPLICATION.—A graduate medical school that
16 desires to receive a grant under this section shall submit
17 to the Secretary an application at such time, in such man-
18 ner, and containing such information as the Secretary may
19 require.

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

23 “(1) The creation of primary care mentorship
24 programs.

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

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

10 “(1) the facility agrees to provide the individual
11 with a scholarship for each school year (not to ex-
12 ceed 4 school years) in which the individual is en-
13 rolled as a full-time student in a school of medicine
14 or a school of osteopathic medicine; and

15 “(2) the individual agrees—

16 “(A) to maintain an acceptable level of
17 academic standing;

18 “(B) to complete a residency in a primary
19 care field; and

20 “(C) after completing the residency, to
21 serve as a primary care physician at such facil-
22 ity in such field for a time period equal to the
23 greater of—

1 “(i) one year for each school year for
2 which the individual was provided a schol-
3 arship under this section; or

4 “(ii) two years.

5 “(c) AMOUNT.—

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

10 “(2) CONSIDERATIONS.—In determining the
11 amount of a scholarship to be provided to an indi-
12 vidual under this section, a health facility may take
13 into consideration the individual’s financial need, ge-
14 ographic differences, and educational costs.

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

19 “(d) APPLICATION OF CERTAIN PROVISIONS.—The
20 provisions of subpart III of part D shall, except as incon-
21 sistent with this section, apply to the program established
22 in subsection (a) in the same manner and to the same
23 extent as such provisions apply to the National Health
24 Service Corps Scholarship Program established in such
25 subpart.

1 “(e) DEFINITIONS.—In this section:

2 “(1) CRITICAL SHORTAGE HEALTH FACILITY.—

3 The term ‘critical shortage health facility’ means a
4 public or private nonprofit health facility that does
5 not serve a health professional shortage area (as
6 designated under section 332), but has a critical
7 shortage of physicians (as determined by the Sec-
8 retary) in a primary care field.

9 “(2) ELIGIBLE INDIVIDUAL.—The term ‘eligible
10 individual’ means an individual who is enrolled, or
11 accepted for enrollment, as a full-time student in an
12 accredited school of medicine or school of osteo-
13 pathic medicine.

14 **“SEC. 340J. LOAN REPAYMENT PROGRAM.**

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

18 “(b) LOAN REPAYMENTS.—The Secretary, acting
19 through the Administrator of the Health Resources and
20 Services Administration, shall establish a program of en-
21 tering into contracts with eligible individuals under
22 which—

23 “(1) the individual agrees to serve—

24 “(A) as a primary care physician or pri-
25 mary care provider in a primary care field; and

1 “(B) in an area that is not a health profes-
2 sional shortage area (as designated under sec-
3 tion 332), but has a critical shortage of primary
4 care physicians and primary care providers (as
5 determined by the Secretary) in such field; and

6 “(2) the Secretary agrees to pay, for each year
7 of such service, not more than \$35,000 of the prin-
8 cipal and interest of the undergraduate or graduate
9 educational loans of the individual.

10 “(c) SERVICE REQUIREMENT.—A contract entered
11 into under this section shall allow the individual receiving
12 the loan repayment to satisfy the service requirement de-
13 scribed in subsection (a)(1) through employment in a solo
14 or group practice, a clinic, a public or private nonprofit
15 hospital, or any other appropriate health care entity.

16 “(d) APPLICATION OF CERTAIN PROVISIONS.—The
17 provisions of subpart III of part D shall, except as incon-
18 sistent with this section, apply to the program established
19 in subsection (a) in the same manner and to the same
20 extent as such provisions apply to the National Health
21 Service Corps Scholarship Program established in such
22 subpart.

23 “(e) DEFINITION.—In this section, the term ‘eligible
24 individual’ means—

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

3 “(2) a primary care provider (as defined in sec-
4 tion 3(a)(7) of the Preserving Patient Access to Pri-
5 mary Care Act of 2009).

6 **“SEC. 340K. LOAN REPAYMENTS FOR PHYSICIANS IN THE**
7 **FIELDS OF OBSTETRICS AND GYNECOLOGY**
8 **AND CERTIFIED NURSE MIDWIVES.**

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

12 “(b) LOAN REPAYMENTS.—The Secretary, acting
13 through the Administrator of the Health Resources and
14 Services Administration, shall establish a program of en-
15 tering into contracts with eligible individuals under
16 which—

17 “(1) the individual agrees to serve—

18 “(A) as a physician in the field of obstet-
19 rics and gynecology or as a certified nurse mid-
20 wife; and

21 “(B) in an area that is not a health profes-
22 sional shortage area (as designated under sec-
23 tion 332), but has a critical shortage of physi-
24 cians in the fields of obstetrics and gynecology

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

3 “(2) the Secretary agrees to pay, for each year
4 of such service, not more than \$35,000 of the prin-
5 cipal and interest of the undergraduate or graduate
6 educational loans of the individual.

7 “(c) SERVICE REQUIREMENT.—A contract entered
8 into under this section shall allow the individual receiving
9 the loan repayment to satisfy the service requirement de-
10 scribed in subsection (a)(1) through employment in a solo
11 or group practice, a clinic, a public or private nonprofit
12 hospital, or any other appropriate health care entity.

13 “(d) APPLICATION OF CERTAIN PROVISIONS.—The
14 provisions of subpart III of part D shall, except as incon-
15 sistent with this section, apply to the program established
16 in subsection (a) in the same manner and to the same
17 extent as such provisions apply to the National Health
18 Service Corps Scholarship Program established in such
19 subpart.

20 “(e) DEFINITION.—In this section, the term ‘eligible
21 individual’ means—

22 “(1) a physician in the field of obstetrics and
23 gynecology; or

24 “(2) a certified nurse midwife.

1 **“SEC. 340L. REPORTS.**

2 “Not later than 18 months after the date of enact-
3 ment of this section, and annually thereafter, the Sec-
4 retary shall submit to Congress a report that describes
5 the programs carried out under this subpart, including
6 statements concerning—

7 “(1) the number of enrollees, scholarships, loan
8 repayments, and grant recipients;

9 “(2) the number of graduates;

10 “(3) the amount of scholarship payments and
11 loan repayments made;

12 “(4) which educational institution the recipients
13 attended;

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

18 “(6) the default rate and actions required;

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

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

23 “(9) the demographics of the individuals par-
24 ticipating in the scholarship and loan repayment
25 programs;

1 “(10) the justification for the allocation of
2 funds between the scholarship and loan repayment
3 programs; and

4 “(11) an evaluation of the overall costs and
5 benefits of the programs.

6 **“SEC. 340M. AUTHORIZATION OF APPROPRIATIONS.**

7 “To carry out sections 340I, 340J, and 340K there
8 are authorized to be appropriated \$55,000,000 for fiscal
9 year 2010, \$90,000,000 for fiscal year 2011, and
10 \$125,000,000 for fiscal year 2012, to be used solely for
11 scholarships and loan repayment awards for primary care
12 physicians and primary care providers.”.

13 **SEC. 103. DEFERMENT OF LOANS DURING RESIDENCY AND**
14 **INTERNSHIPS.**

15 (a) LOAN REQUIREMENTS.—Section 427(a)(2)(C)(i)
16 of the Higher Education Act of 1965 (20 U.S.C.
17 1077(a)(2)(C)(i)) is amended by inserting “unless the
18 medical internship or residency program is in a primary
19 care field (as defined in section 3(a)(5) of the Preserving
20 Patient Access to Primary Care Act of 2009)” after “resi-
21 dency program”.

22 (b) FFEL LOANS.—Section 428(b)(1)(M)(i) of the
23 Higher Education Act of 1965 (20 U.S.C.
24 1078(b)(1)(M)(i)) is amended by inserting “unless the
25 medical internship or residency program is in a primary

1 care field (as defined in section 3(a)(5) of the Preserving
2 Patient Access to Primary Care Act of 2009)” after “resi-
3 dency program”.

4 (c) FEDERAL DIRECT LOANS.—Section 455(f)(2)(A)
5 of the Higher Education Act of 1965 (20 U.S.C.
6 1087e(f)(2)(A)) is amended by inserting “unless the med-
7 ical internship or residency program is in a primary care
8 field (as defined in section 3(a)(5) of the Preserving Pa-
9 tient Access to Primary Care Act of 2009)” after “resi-
10 dency program”.

11 (d) FEDERAL PERKINS LOANS.—Section
12 464(e)(2)(A)(i) of the Higher Education Act of 1965 (20
13 U.S.C. 1087dd(e)(2)(A)(i)) is amended by inserting “un-
14 less the medical internship or residency program is in a
15 primary care field (as defined in section 3(a)(5) of the
16 Preserving Patient Access to Primary Care Act of 2009)”
17 after “residency program”.

18 **SEC. 104. EDUCATING MEDICAL STUDENTS ABOUT PRI-**
19 **MARY CARE CAREERS.**

20 Part C of title VII of the Public Health Service Act
21 (42 U.S.C. 293k) is amended by adding at the end the
22 following:

1 **“SEC. 749. EDUCATING MEDICAL STUDENTS ABOUT PRI-**
2 **MARY CARE CAREERS.**

3 “(a) IN GENERAL.—The Secretary shall award
4 grants to eligible State and local government entities for
5 the development of informational materials that promote
6 careers in primary care by highlighting the advantages
7 and rewards of primary care, and that encourage medical
8 students, particularly students from disadvantaged back-
9 grounds, to become primary care physicians.

10 “(b) ANNOUNCEMENT.—The grants described in sub-
11 section (a) shall be announced through a publication in
12 the Federal Register and through appropriate media out-
13 lets in a manner intended to reach medical education insti-
14 tutions, associations, physician groups, and others who
15 communicate with medical students.

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

18 “(1) be a State or local entity; and

19 “(2) submit to the Secretary an application at
20 such time, in such manner, and containing such in-
21 formation as the Secretary may require.

22 “(d) USE OF FUNDS.—

23 “(1) IN GENERAL.—An entity shall use
24 amounts received under a grant under this section to
25 support State and local campaigns through appro-
26 priate media outlets to promote careers in primary

1 care and to encourage individuals from disadvan-
2 taged backgrounds to enter and pursue careers in
3 primary care.

4 “(2) SPECIFIC USES.—In carrying out activities
5 under paragraph (1), an entity shall use grants
6 funds to develop informational materials in a man-
7 ner intended to reach as wide and diverse an audi-
8 ence of medical students as possible, in order to—

9 “(A) advertise and promote careers in pri-
10 mary care;

11 “(B) promote primary care medical edu-
12 cation programs;

13 “(C) inform the public of financial assist-
14 ance regarding such education programs;

15 “(D) highlight individuals in the commu-
16 nity who are practicing primary care physicians;
17 or

18 “(E) provide any other information to re-
19 cruit individuals for careers in primary care.

20 “(e) LIMITATION.—An entity shall not use amounts
21 received under a grant under this section to advertise par-
22 ticular employment opportunities.

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

1 such sums as may be necessary for each of fiscal years
2 2010 through 2013.”.

3 **SEC. 105. TRAINING IN A FAMILY MEDICINE, GENERAL IN-**
4 **TERNAL MEDICINE, GENERAL GERIATRICS,**
5 **GENERAL PEDIATRICS, PHYSICIAN ASSIST-**
6 **ANT EDUCATION, GENERAL DENTISTRY, AND**
7 **PEDIATRIC DENTISTRY.**

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

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

15 **SEC. 106. INCREASED FUNDING FOR NATIONAL HEALTH**
16 **SERVICE CORPS SCHOLARSHIP AND LOAN**
17 **REPAYMENT PROGRAMS.**

18 (a) IN GENERAL.—There is authorized to be appro-
19 priated \$332,000,000 for the period of fiscal years 2010
20 through 2012 for the purpose of carrying out subpart III
21 of part D of title III of the Public Health Service Act
22 (42 U.S.C. 254l et seq.). Such authorization of appropria-
23 tions is in addition to the authorization of appropriations
24 in section 338H of such Act (42 U.S.C. 254q) and any
25 other authorization of appropriations for such purpose.

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

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

8 (2) have not previously received a scholarship or
 9 loan repayment under subpart III of part D of title
 10 III of the Public Health Service Act (42 U.S.C. 2541
 11 et seq.).

12 **TITLE II—MEDICAID RELATED** 13 **PROVISIONS**

14 **SEC. 201. TRANSFORMATION GRANTS TO SUPPORT PA-** 15 **TIENT CENTERED MEDICAL HOMES UNDER** 16 **MEDICAID AND CHIP.**

17 (a) IN GENERAL.—Section 1903(z) of the Social Se-
 18 curity Act (42 U.S.C. 1396b(z)) is amended—

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

21 “(G) Methods for improving the effective-
 22 ness and efficiency of medical assistance pro-
 23 vided under this title and child health assist-
 24 ance provided under title XXI by encouraging
 25 the adoption of medical practices that satisfy

1 the standards established by the Secretary
2 under paragraph (2) of section 3(d) of the Pre-
3 serving Patient Access to Primary Care Act of
4 2009 for medical practices to qualify as patient
5 centered medical homes (as defined in para-
6 graph (1) of such section).”; and

7 (2) in paragraph (4)—

8 (A) in subparagraph (A)—

9 (i) in clause (i), by striking “and” at
10 the end;

11 (ii) in clause (ii), by striking the pe-
12 riod at the end and inserting “; and”; and

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

15 “(iii) \$25,000,000 for each of fiscal
16 years 2010, 2011, and 2012.”; and

17 (B) in subparagraph (B), by striking the
18 second and third sentences and inserting the
19 following: “Such method shall provide that 100
20 percent of such funds for each of fiscal years
21 2010, 2011, and 2012 shall be allocated among
22 States that design programs to adopt the inno-
23 vative methods described in paragraph (2)(G),
24 with preference given to States that design pro-
25 grams involving multipayers (including under

1 title XVIII and private health plans) test
 2 projects for implementation of the elements nec-
 3 essary to be recognized as a patient centered
 4 medical home practice under the National Com-
 5 mittee for Quality Assurance Physicians Prac-
 6 tice Connection-PCMH module (or any other
 7 equivalent process, as determined by the Sec-
 8 retary).”.

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

11 **TITLE III—MEDICARE**

12 **PROVISIONS**

13 **Subtitle A—Primary Care**

14 **SEC. 301. REFORMING PAYMENT SYSTEMS UNDER MEDI-** 15 **CARE TO SUPPORT PRIMARY CARE.**

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

22 (1) in clause (ii)(II), by striking “(iv) and (v)”
 23 and inserting “(iv), (v), and (vii)”; and

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

1 “(vii) INCREASE IN LIMITATION TO
2 ACCOUNT FOR CERTAIN ANTICIPATED SAV-
3 INGS.—

4 “(I) IN GENERAL.—Effective for
5 fee schedules established beginning
6 with 2010, the Secretary shall in-
7 crease the limitation on annual ad-
8 justments under clause (ii)(II) by an
9 amount equal to the anticipated sav-
10 ings under parts A, B, and D (includ-
11 ing any savings with respect to items
12 and services for which payment is not
13 made under this section) which are a
14 result of payments for designated pri-
15 mary care services and comprehensive
16 care coordination services under sec-
17 tion 1834(m) and the coverage of pa-
18 tient centered medical home services
19 under section 1861(s)(2)(FF) (as de-
20 termined by the Secretary).

21 “(II) MECHANISM TO DETER-
22 MINE APPLICATION OF INCREASE.—
23 The Secretary shall establish a mecha-
24 nism for determining which relative
25 value units established under this

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

5 “(III) ADDITIONAL FUNDING AS
 6 DETERMINED NECESSARY BY THE
 7 SECRETARY.—In addition to any
 8 funding that may be made available
 9 as a result of an increase in the limi-
 10 tation on annual adjustments under
 11 subclause (I), there shall also be avail-
 12 able to the Secretary, for purposes of
 13 making payments under this title for
 14 new services and capabilities to im-
 15 prove care provided to individuals
 16 under this title and to generate effi-
 17 ciencies under this title, such addi-
 18 tional funds as the Secretary deter-
 19 mines are necessary.”.

20 (b) SEPARATE MEDICARE PAYMENT FOR DES-
 21 IGNATED PRIMARY CARE SERVICES AND COMPREHENSIVE
 22 CARE COORDINATION SERVICES.—

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

1 “(n) PAYMENT FOR DESIGNATED PRIMARY CARE
2 SERVICES AND COMPREHENSIVE CARE COORDINATION
3 SERVICES.—

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

8 “(2) PAYMENT AMOUNT.—The Secretary shall
9 determine the amount of payment for designated
10 primary care services and comprehensive care co-
11 ordination services under this subsection.

12 “(3) DOCUMENTATION REQUIREMENTS.—The
13 Secretary shall propose appropriate documentation
14 requirements to justify payments for designated pri-
15 mary care services and comprehensive care coordina-
16 tion services under this subsection.

17 “(4) DEFINITIONS.—

18 “(A) COMPREHENSIVE CARE COORDINA-
19 TION SERVICES.—The term ‘comprehensive care
20 coordination services’ means care coordination
21 services with procedure codes established by the
22 Secretary (as appropriate) which are furnished
23 to an individual enrolled under this part by a
24 primary care provider or principal care physi-
25 cian.

1 “(B) DESIGNATED PRIMARY CARE SERV-
2 ICES.—The term ‘designated primary care serv-
3 ice’ means a service which the Secretary deter-
4 mines has a procedure code which involves a
5 clinical interaction with an individual enrolled
6 under this part that is inherent to care coordi-
7 nation, including interactions outside of a face-
8 to-face encounter. Such term includes the fol-
9 lowing:

10 “(i) Care plan oversight.

11 “(ii) Evaluation and management pro-
12 vided by phone.

13 “(iii) Evaluation and management
14 provided using internet resources.

15 “(iv) Collection and review of physio-
16 logic data, such as from a remote moni-
17 toring device.

18 “(v) Education and training for pa-
19 tient self management.

20 “(vi) Anticoagulation management
21 services.

22 “(vii) Any other service determined
23 appropriate by the Secretary.”.

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

4 **SEC. 302. COVERAGE OF PATIENT CENTERED MEDICAL**
5 **HOME SERVICES.**

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

8 (1) in subparagraph (DD), by striking “and” at
9 the end;

10 (2) in subparagraph (EE), by inserting “and”
11 at the end; and

12 (3) by adding at the end the following new sub-
13 paragraph:

14 “(FF) patient centered medical home services
15 (as defined in subsection (hhh)(1));”.

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

20 “Patient Centered Medical Home Services

21 “(hhh)(1) The term ‘patient centered medical home
22 services’ means care coordination services furnished by a
23 qualified patient centered medical home.

24 “(2) The term ‘qualified patient centered medical
25 home’ means a patient centered medical home (as defined

1 in section 3(d) of the Preserving Patient Access to Pri-
2 mary Care Act of 2009).”.

3 (c) MONTHLY FEE FOR PATIENT CENTERED MED-
4 ICAL HOME SERVICES.—Section 1848 of the Social Secu-
5 rity Act (42 U.S.C. 1395w-4) is amended by adding at
6 the end the following new subsection:

7 “(p) MONTHLY FEE FOR PATIENT CENTERED MED-
8 ICAL HOME SERVICES.—

9 “(1) MONTHLY FEE.—

10 “(A) IN GENERAL.—Not later than Janu-
11 ary 1, 2012, the Secretary shall establish a pay-
12 ment methodology for patient centered medical
13 home services (as defined in paragraph (1) of
14 section 1861(hhh)). Under such payment meth-
15 odology, the Secretary shall pay qualified pa-
16 tient centered medical homes (as defined in
17 paragraph (2) of such section) a monthly fee
18 for each individual who elects to receive patient
19 centered medical home services at that medical
20 home. Such fee shall be paid on a prospective
21 basis.

22 “(B) CONSIDERATIONS.—The Secretary
23 shall take into account the results of the Medi-
24 care medical home demonstration project under
25 section 204 of the Medicare Improvement and

1 Extension Act of 2006 (42 U.S.C. 1395b-1
2 note; division B of Public Law 109-432) in es-
3 tablishing the payment methodology under sub-
4 paragraph (A).

5 “(2) AMOUNT OF PAYMENT.—

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

9 “(i) The clinical work and practice ex-
10 penses involved in providing care coordina-
11 tion services consistent with the patient
12 centered medical home model (such as pro-
13 viding increased access, care coordination,
14 disease population management, and edu-
15 cation) for which payment is not made
16 under this section as of the date of enact-
17 ment of this subsection.

18 “(ii) Ensuring that the amount of
19 payment is sufficient to support the acqui-
20 sition, use, and maintenance of clinical in-
21 formation systems which—

22 “(I) are needed by a qualified pa-
23 tient centered medical home; and

1 “(II) have been shown to facili-
2 tate improved outcomes through care
3 coordination.

4 “(iii) The establishment of a tiered
5 monthly care management fee that pro-
6 vides for a range of payment depending on
7 how advanced the capabilities of a qualified
8 patient centered medical home are in hav-
9 ing the information systems needed to sup-
10 port care coordination.

11 “(B) RISK-ADJUSTMENT.—The Secretary
12 shall use appropriate risk-adjustment in deter-
13 mining the amount of the monthly fee under
14 this paragraph.

15 “(3) FUNDING.—

16 “(A) IN GENERAL.—The Secretary shall
17 determine the aggregate estimated savings for a
18 calendar year as a result of the implementation
19 of this subsection on reducing preventable hos-
20 pital admissions, duplicate testing, medication
21 errors and drug interactions, and other savings
22 under this part and part A (including any sav-
23 ings with respect to items and services for
24 which payment is not made under this section).

1 “(B) FUNDING.—Subject to subparagraph
2 (C), the aggregate amount available for pay-
3 ment of the monthly fee under this subsection
4 during a calendar year shall be equal to the ag-
5 gregate estimated savings (as determined under
6 subparagraph (A)) for the calendar year (as de-
7 termined by the Secretary).

8 “(C) ADDITIONAL FUNDING.—In the case
9 where the amount of the aggregate actual sav-
10 ings during the preceding 3 years exceeds the
11 amount of the aggregate estimated savings (as
12 determined under subparagraph (A)) during
13 such period, the aggregate amount available for
14 payment of the monthly fee under this sub-
15 section during the calendar year (as determined
16 under subparagraph (B)) shall be increased by
17 the amount of such excess.

18 “(D) ADDITIONAL FUNDING AS DETER-
19 MINED NECESSARY BY THE SECRETARY.—In
20 addition to any funding made available under
21 subparagraphs (B) and (C), there shall also be
22 available to the Secretary, for purposes of effec-
23 tively implementing this subsection, such addi-
24 tional funds as the Secretary determines are
25 necessary.

1 “(4) PERFORMANCE-BASED BONUS PAY-
2 MENTS.—The Secretary shall establish a process for
3 paying a performance-based bonus to qualified pa-
4 tient centered medical homes which meet or achieve
5 substantial improvements in performance (as speci-
6 fied under clinical, patient satisfaction, and effi-
7 ciency benchmarks established by the Secretary).
8 Such bonus shall be in an amount determined appro-
9 priate by the Secretary.

10 “(5) NO EFFECT ON PAYMENTS FOR EVALUA-
11 TION AND MANAGEMENT SERVICES.—The monthly
12 fee under this subsection shall have no effect on the
13 amount of payment for evaluation and management
14 services under this title.”.

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

17 (1) by striking “and” before “(W)”; and

18 (2) by inserting before the semicolon at the end
19 the following: “, and (X) with respect to patient cen-
20 tered medical home services (as defined in section
21 1861(hhh)(1)), the amount paid shall be (i) in the
22 case of such services which are physicians’ services,
23 the amount determined under subparagraph (N),
24 and (ii) in the case of all other such services, 80 per-
25 cent of the lesser of the actual charge for the service

1 or the amount determined under a fee schedule es-
2 tablished by the Secretary for purposes of this sub-
3 paragraph”.

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

7 **SEC. 303. MEDICARE PRIMARY CARE PAYMENT EQUITY AND**
8 **ACCESS PROVISION.**

9 (a) IN GENERAL.—Section 1848 of the Social Secu-
10 rity Act (42 U.S.C. 1395w-4), as amended by section
11 302(e), is amended by adding at the end the following new
12 subsection:

13 “(q) PRIMARY CARE PAYMENT EQUITY AND AC-
14 CESS.—

15 “(1) IN GENERAL.—Not later than January 1,
16 2010, the Secretary shall develop a methodology, in
17 consultation with primary care physician organiza-
18 tions and primary care provider organizations, the
19 Medicare Payment Advisory Commission, and other
20 experts, to increase payments under this section for
21 designated evaluation and management services pro-
22 vided by primary care physicians, primary care pro-
23 viders, and principal care providers through 1 or
24 more of the following:

1 “(A) A service-specific modifier to the rel-
2 ative value units established for such services.

3 “(B) Service-specific bonus payments.

4 “(C) Any other methodology determined
5 appropriate by the Secretary.

6 “(2) INCLUSION OF PROPOSED CRITERIA.—The
7 methodology developed under paragraph (1) shall in-
8 clude proposed criteria for providers to qualify for
9 such increased payments, including consideration
10 of—

11 “(A) the type of service being rendered;

12 “(B) the specialty of the provider providing
13 the service; and

14 “(C) demonstration by the provider of vol-
15 untary participation in programs to improve
16 quality, such as participation in the Physician
17 Quality Reporting Initiative (as determined by
18 the Secretary) or practice-level qualification as
19 a patient centered medical home.

20 “(3) FUNDING.—

21 “(A) DETERMINATION.—The Secretary
22 shall determine the aggregate estimated savings
23 for a calendar year as a result of such increased
24 payments on reducing preventable hospital ad-
25 missions, duplicate testing, medication errors

1 and drug interactions, Intensive Care Unit ad-
2 missions, per capita health care expenditures,
3 and other savings under this part and part A
4 (including any savings with respect to items
5 and services for which payment is not made
6 under this section).

7 “(B) FUNDING.—The aggregate amount
8 available for such increased payments during a
9 calendar year shall be equal to the aggregate
10 estimated savings (as determined under sub-
11 paragraph (A)) for the calendar year (as deter-
12 mined by the Secretary).

13 “(C) ADDITIONAL FUNDING AS DETER-
14 MINED NECESSARY BY THE SECRETARY.—In
15 addition to any funding made available under
16 subparagraph (B), there shall also be available
17 to the Secretary, for purposes of effectively im-
18 plementing this subsection, such additional
19 funds as the Secretary determines are nec-
20 essary.”.

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

1 **SEC. 304. ADDITIONAL INCENTIVE PAYMENT PROGRAM**
 2 **FOR PRIMARY CARE SERVICES FURNISHED**
 3 **IN HEALTH PROFESSIONAL SHORTAGE**
 4 **AREAS.**

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

8 “(x) ADDITIONAL INCENTIVE PAYMENTS FOR PRI-
 9 MARY CARE SERVICES FURNISHED IN HEALTH PROFES-
 10 SIONAL SHORTAGE AREAS.—

11 “(1) IN GENERAL.—In the case of primary care
 12 services furnished on or after January 1, 2010, by
 13 a primary care physician or primary care provider in
 14 an area that is designated (under section
 15 332(a)(1)(A) of the Public Health Service Act) as a
 16 health professional shortage area as identified by the
 17 Secretary prior to the beginning of the year involved,
 18 in addition to the amount of payment that would
 19 otherwise be made for such services under this part,
 20 there also shall be paid (on a monthly or quarterly
 21 basis) an amount equal to 10 percent of the pay-
 22 ment amount for the service under this part.

23 “(2) DEFINITIONS.—In this subsection:

24 “(A) PRIMARY CARE PHYSICIAN; PRIMARY
 25 CARE PROVIDER.—The terms ‘primary care
 26 physician’ and ‘primary care provider’ have the

1 meaning given such terms in paragraphs (6)
2 and (7), respectively, of section 3(a) of the Pre-
3 serving Patient Access to Primary Care Act of
4 2009.

5 “(B) PRIMARY CARE SERVICES.—The term
6 ‘primary care services’ means procedure codes
7 for services in the category of the Healthcare
8 Common Procedure Coding System, as estab-
9 lished by the Secretary under section
10 1848(c)(5) (as of December 31, 2008, and as
11 subsequently modified by the Secretary) con-
12 sisting of evaluation and management services,
13 but limited to such procedure codes in the cat-
14 egory of office or other outpatient services, and
15 consisting of subcategories of such procedure
16 codes for services for both new and established
17 patients.

18 “(3) JUDICIAL REVIEW.—There shall be no ad-
19 ministrative or judicial review under section 1869,
20 1878, or otherwise, respecting the identification of
21 primary care physicians, primary care providers, or
22 primary care services under this subsection.”.

23 (b) CONFORMING AMENDMENT.—Section
24 1834(g)(2)(B) of the Social Security Act (42 U.S.C.
25 1395m(g)(2)(B)) is amended by adding at the end the fol-

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

4 **SEC. 305. PERMANENT EXTENSION OF FLOOR ON MEDI-**
5 **CARE WORK GEOGRAPHIC ADJUSTMENT**
6 **UNDER THE MEDICARE PHYSICIAN FEE**
7 **SCHEDULE.**

8 Section 1848(e)(1)(E) of the Social Security Act (42
9 U.S.C. 1395w-4(e)(1)(E)) is amended by striking “and
10 before January 1, 2010,”.

11 **SEC. 306. PERMANENT EXTENSION OF MEDICARE INCEN-**
12 **TIVE PAYMENT PROGRAM FOR PHYSICIAN**
13 **SCARCITY AREAS.**

14 Section 1833(u) of the Social Security Act (42 U.S.C.
15 1395l(u)) is amended—

16 (1) in paragraph (1)—

17 (A) by inserting “or on or after July 1,
18 2009” after “before July 1, 2008”; and

19 (B) by inserting “(or, in the case of serv-
20 ices furnished on or after July 1, 2009, 10 per-
21 cent)” after “5 percent”; and

22 (2) in paragraph (4)(D), by striking “before
23 July 1, 2008” and inserting “before January 1,
24 2010”.

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

4 (a) STUDY.—The Secretary shall conduct a study on
5 the process used by the Secretary for determining relative
6 value under the Medicare physician fee schedule under
7 section 1848(c) of the Social Security Act (42 U.S.C.
8 1395w–4(c)). Such study shall include an analysis of the
9 following:

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

13 (B) any changes that may be necessary to en-
14 sure such equitable representation.

15 (2)(A) Whether the existing process provides
16 the Secretary with expert and impartial input from
17 physicians in medical specialties that provide pri-
18 mary care to patients with multiple chronic diseases,
19 the fastest growing part of the Medicare population;
20 and

21 (B) any changes that may be necessary to en-
22 sure such input.

23 (3)(A) Whether the existing process includes
24 equitable representation of physician medical special-
25 ties in proportion to their relative contributions to-
26 ward caring for Medicare beneficiaries, as deter-

1 by striking “more than” and all that follows before the
2 comma at the end and inserting “more than one time dur-
3 ing the lifetime of the individual”.

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

7 **SEC. 312. ELIMINATION OF COST-SHARING FOR PREVEN-**
8 **TIVE BENEFITS UNDER THE MEDICARE PRO-**
9 **GRAM.**

10 (a) DEFINITION OF PREVENTIVE SERVICES.—Sec-
11 tion 1861(ddd) of the Social Security Act (42 U.S.C.
12 1395w(dd)) is amended—

13 (1) in the heading, by inserting “; Preventive
14 Services” after “Services”;

15 (2) in paragraph (1), by striking “not otherwise
16 described in this title” and inserting “not described
17 in subparagraphs (A) through (N) of paragraph
18 (3)”; and

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

21 “(3) The term ‘preventive services’ means the fol-
22 lowing:

23 “(A) Prostate cancer screening tests (as defined
24 in subsection (oo)).

1 “(B) Colorectal cancer screening tests (as de-
2 fined in subsection (pp)).

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

5 “(D) Screening for glaucoma for certain indi-
6 viduals (as described in subsection (s)(2)(U)).

7 “(E) Medical nutrition therapy services for cer-
8 tain individuals (as described in subsection
9 (s)(2)(V)).

10 “(F) An initial preventive physical examination
11 (as defined in subsection (ww)).

12 “(G) Cardiovascular screening blood tests (as
13 defined in subsection (xx)(1)).

14 “(H) Diabetes screening tests (as defined in
15 subsection (yy)).

16 “(I) Ultrasound screening for abdominal aortic
17 aneurysm for certain individuals (as described in
18 subsection (s)(2)(AA)).

19 “(J) Pneumococcal and influenza vaccine and
20 their administration (as described in subsection
21 (s)(10)(A)).

22 “(K) Hepatitis B vaccine and its administration
23 for certain individuals (as described in subsection
24 (s)(10)(B)).

1 “(L) Screening mammography (as defined in
2 subsection (jj)).

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

5 “(N) Bone mass measurement (as defined in
6 subsection (rr)).

7 “(O) Additional preventive services (as deter-
8 mined under paragraph (1)).”.

9 (b) COINSURANCE.—

10 (1) GENERAL APPLICATION.—

11 (A) IN GENERAL.—Section 1833(a)(1) of
12 the Social Security Act (42 U.S.C.
13 1395l(a)(1)), as amended by section 302, is
14 amended—

15 (i) in subparagraph (T), by striking
16 “80 percent” and inserting “100 percent”;

17 (ii) in subparagraph (W), by striking
18 “80 percent” and inserting “100 percent”;

19 (iii) by striking “and” before “(X)”;

20 and

21 (iv) by inserting before the semicolon
22 at the end the following: “, and (Y) with
23 respect to preventive services described in
24 subparagraphs (A) through (O) of section
25 1861(ddd)(3), the amount paid shall be

1 100 percent of the lesser of the actual
 2 charge for the services or the amount de-
 3 termined under the fee schedule that ap-
 4 plies to such services under this part”.

5 (2) ELIMINATION OF COINSURANCE FOR
 6 SCREENING SIGMOIDOSCOPIES AND
 7 COLONOSCOPIES.—Section 1834(d) of the Social Se-
 8 curity Act (42 U.S.C. 1395m(d)) is amended—

9 (A) in paragraph (2)—

10 (i) in subparagraph (A), by inserting
 11 “, except that payment for such tests
 12 under such section shall be 100 percent of
 13 the payment determined under such sec-
 14 tion for such tests” before the period at
 15 the end; and

16 (ii) in subparagraph (C)—

17 (I) by striking clause (ii); and

18 (II) in clause (i)—

19 (aa) by striking “(i) IN GEN-
 20 ERAL.—Notwithstanding” and
 21 inserting “Notwithstanding”;

22 (bb) by redesignating sub-
 23 clauses (I) and (II) as clauses (i)
 24 and (ii), respectively, and moving

1 such clauses 2 ems to the left;
2 and

3 (cc) in the flush matter fol-
4 lowing clause (ii), as so redesign-
5 nated, by inserting “100 percent
6 of” after “based on”; and

7 (B) in paragraph (3)—

8 (i) in subparagraph (A), by inserting
9 “, except that payment for such tests
10 under such section shall be 100 percent of
11 the payment determined under such sec-
12 tion for such tests” before the period at
13 the end; and

14 (ii) in subparagraph (C)—

15 (I) by striking clause (ii); and

16 (II) in clause (i)—

17 (aa) by striking “(i) IN GEN-
18 ERAL.—Notwithstanding” and
19 inserting “Notwithstanding”; and

20 (bb) by inserting “100 per-
21 cent of” after “based on”.

22 (3) ELIMINATION OF COINSURANCE IN OUT-
23 PATIENT HOSPITAL SETTINGS.—

24 (A) EXCLUSION FROM OPD FEE SCHED-
25 ULE.—Section 1833(t)(1)(B)(iv) of the Social

1 Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is
2 amended by striking “and diagnostic mammog-
3 raphy” and inserting “, diagnostic mammog-
4 raphy, and preventive services (as defined in
5 section 1861(ddd)(3))”.

6 (B) CONFORMING AMENDMENTS.—Section
7 1833(a)(2) of the Social Security Act (42
8 U.S.C. 1395l(a)(2)) is amended—

9 (i) in subparagraph (F), by striking
10 “and” after the semicolon at the end;

11 (ii) in subparagraph (G)(ii), by adding
12 “and” at the end; and

13 (iii) by adding at the end the fol-
14 lowing new subparagraph:

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

20 (c) WAIVER OF APPLICATION OF DEDUCTIBLE.—The
21 first sentence of section 1833(b) of the Social Security Act
22 (42 U.S.C. 1395l(b)) is amended—

23 (1) in clause (1), by striking “items and serv-
24 ices described in section 1861(s)(10)(A)” and insert-

1 ing “preventive services (as defined in section
2 1861(ddd)(3))”;

3 (2) by inserting “and” before “(4)”; and

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

6 **SEC. 313. HHS STUDY AND REPORT ON FACILITATING THE**
7 **RECEIPT OF MEDICARE PREVENTIVE SERV-**
8 **ICES BY MEDICARE BENEFICIARIES.**

9 (a) STUDY.—The Secretary, in consultation with pro-
10 vider organizations and other appropriate stakeholders,
11 shall conduct a study on—

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

15 (A) furnishing appropriate preventive serv-
16 ices (as defined in section 1861(ddd)(3) of the
17 Social Security Act, as added by section 312) to
18 individuals enrolled under part B of title XVIII
19 of such Act; and

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

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

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

5 (B) incorporating the resulting clinical in-
6 formation into the treatment plan for the indi-
7 vidual.

8 (b) REPORT.—Not later than 12 months after the
9 date of enactment of this Act, the Secretary shall submit
10 to Congress a report containing the results of the study
11 conducted under subsection (a), together with rec-
12 ommendations for such legislation and administrative ac-
13 tion as the Secretary determines appropriate.

14 **Subtitle C—Other Provisions**

15 **SEC. 321. HHS STUDY AND REPORT ON IMPROVING THE** 16 **ABILITY OF PHYSICIANS AND PRIMARY CARE** 17 **PROVIDERS TO ASSIST MEDICARE BENE-** 18 **FICIARIES IN OBTAINING NEEDED PRESCRIP-** 19 **TIONS UNDER MEDICARE PART D.**

20 (a) STUDY.—The Secretary, in consultation with phy-
21 sician organizations and other appropriate stakeholders,
22 shall conduct a study on the development and implementa-
23 tion of mechanisms to facilitate increased efficiency relat-
24 ing to the role of physicians and primary care providers
25 in Medicare beneficiaries obtaining needed prescription

1 drugs under the Medicare prescription drug program
2 under part D of title XVIII of the Social Security Act.

3 Such study shall include an analysis of ways to—

4 (1) improve the accessibility of formulary infor-
5 mation;

6 (2) streamline the prior authorization, excep-
7 tion, and appeals processes, through, at a minimum,
8 standardizing formats and allowing electronic ex-
9 change of information; and

10 (3) recognize the work of the physician and pri-
11 mary care provider involved in the prescribing proc-
12 ess, especially work that may extend beyond the
13 amount considered to be bundled into payment for
14 evaluation and management services.

15 (b) REPORT.—Not later than 12 months after the
16 date of enactment of this Act, the Secretary shall submit
17 to Congress a report containing the results of the study
18 conducted under subsection (a), together with rec-
19 ommendations for such legislation and administrative ac-
20 tion as the Secretary determines appropriate.

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

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

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

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

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

16 (b) REPORT.—Not later than 12 months after the
17 date of enactment of this Act, the Secretary shall submit
18 to Congress a report containing the results of the study
19 conducted under subsection (a), together with rec-
20 ommendations for such legislation and administrative ac-
21 tion as the Secretary determines appropriate.

1 **SEC. 323. IMPROVED PATIENT CARE THROUGH EXPANDED**
2 **SUPPORT FOR LIMITED ENGLISH PRO-**
3 **FICIENCY (LEP) SERVICES.**

4 (a) ADDITIONAL PAYMENTS FOR PRIMARY CARE
5 PHYSICIANS AND PRIMARY CARE PROVIDERS.—Section
6 1833 of the Social Security Act (42 U.S.C. 1395l), as
7 amended by section 304, is amended by adding at the end
8 the following new subsection:

9 “(y) ADDITIONAL PAYMENTS FOR PROVIDING SERV-
10 ICES TO INDIVIDUALS WITH LIMITED ENGLISH PRO-
11 FICIENCY.—

12 “(1) IN GENERAL.—In the case of primary care
13 providers’ services furnished on or after January 1,
14 2010, to an individual with limited English pro-
15 ficiency by a provider, in addition to the amount of
16 payment that would otherwise be made for such
17 services under this part, there shall also be paid an
18 appropriate amount (as determined by the Sec-
19 retary) in order to recognize the additional time in-
20 volved in furnishing the service to such individual.

21 “(2) JUDICIAL REVIEW.—There shall be no ad-
22 ministrative or judicial review under section 1869,
23 1878, or otherwise, respecting the determination of
24 the amount of additional payment under this sub-
25 section.”.

1 (b) NATIONAL CLEARINGHOUSE.—Not later than
2 180 days after the date of enactment of this Act, the Sec-
3 retary shall establish a national clearinghouse to make
4 available to the primary care physicians, primary care pro-
5 viders, patients, and States translated documents regard-
6 ing patient care and education under the Medicare pro-
7 gram, the Medicaid program, and the State Children’s
8 Health Insurance Program under titles XVIII, XIX, and
9 XXI, respectively, of the Social Security Act.

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

12 (1) AUTHORITY TO AWARD GRANTS.—The Sec-
13 retary shall award grants to support language trans-
14 lation services for primary care physicians and pri-
15 mary care providers in medically underserved areas
16 (as defined in section 3(c)).

17 (2) AUTHORIZATION OF APPROPRIATIONS.—
18 There are authorized to be appropriated to the Sec-
19 retary to award grants under this subsection, such
20 sums as are necessary for fiscal years beginning with
21 fiscal year 2010.

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

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

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

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

8 (c) REPORT.—Not later than January 1, 2011, the
9 Secretary shall submit to Congress a report containing the
10 results of the study conducted under subsection (a), to-
11 gether with recommendations for such legislation and ad-
12 ministrative action as the Secretary determines appro-
13 priate.

14 **SEC. 325. ONGOING ASSESSMENT BY MEDPAC OF THE IM-**
15 **PACT OF MEDICARE PAYMENTS ON PRIMARY**
16 **CARE ACCESS AND EQUITY.**

17 The Medicare Payment Advisory Commission, begin-
18 ning in 2010 and in each of its subsequent annual reports
19 to Congress on Medicare physician payment policies, shall
20 provide an assessment of the impact of changes in Medi-
21 care payment policies in improving access to and equity
22 of payments to primary care physicians and primary care
23 providers. Such assessment shall include an assessment of
24 the effectiveness, once implemented, of the Medicare pay-
25 ment-related reforms required by this Act to support pri-

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

5 **SEC. 326. DISTRIBUTION OF ADDITIONAL RESIDENCY POSI-**
 6 **TIONS.**

7 (a) IN GENERAL.—Section 1886(h) of the Social Se-
 8 curity Act (42 U.S.C. 1395ww(h)) is amended—

9 (1) in paragraph (4)(F)(i), by striking “para-
 10 graph (7)” and inserting “paragraphs (7) and (8)”;

11 (2) in paragraph (4)(H)(i), by striking “para-
 12 graph (7)” and inserting “paragraphs (7) and (8)”;

13 and

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

16 “(8) DISTRIBUTION OF ADDITIONAL RESIDENCY
 17 POSITIONS.—

18 “(A) ADDITIONAL RESIDENCY POSI-
 19 TIONS.—

20 “(i) REDUCTION IN LIMIT BASED ON
 21 UNUSED POSITIONS.—

22 “(I) IN GENERAL.—The Sec-
 23 retary shall reduce the otherwise ap-
 24 plicable resident limit for a hospital
 25 that the Secretary determines had

1 residency positions that were unused
2 for all 5 of the most recent cost re-
3 porting periods ending prior to the
4 date of enactment of this paragraph
5 by an amount that is equal to the
6 number of such unused residency po-
7 sitions.

8 “(II) EXCEPTION FOR RURAL
9 HOSPITALS AND CERTAIN OTHER HOS-
10 PITALS.—This subparagraph shall not
11 apply to a hospital—

12 “(aa) located in a rural area
13 (as defined in subsection
14 (d)(2)(D)(ii));

15 “(bb) that has participated
16 in a voluntary reduction plan
17 under paragraph (6); or

18 “(cc) that has participated
19 in a demonstration project ap-
20 proved as of October 31, 2003,
21 under the authority of section
22 402 of Public Law 90–248.

23 “(ii) NUMBER AVAILABLE FOR DIS-
24 TRIBUTION.—The number of additional
25 residency positions available for distribu-

1 tion under subparagraph (B) shall be an
2 amount that the Secretary determines
3 would result in a 15 percent increase in
4 the aggregate number of full-time equiva-
5 lent residents in approved medical training
6 programs (as determined based on the
7 most recent cost reports available at the
8 time of distribution). One-third of such
9 number shall only be available for distribu-
10 tion to hospitals described in subclause (I)
11 of subparagraph (B)(ii) under such sub-
12 paragraph.

13 “(B) DISTRIBUTION.—

14 “(i) IN GENERAL.—The Secretary
15 shall increase the otherwise applicable resi-
16 dent limit for each qualifying hospital that
17 submits an application under this subpara-
18 graph by such number as the Secretary
19 may approve for portions of cost reporting
20 periods occurring on or after the date of
21 enactment of this paragraph. The aggre-
22 gate number of increases in the otherwise
23 applicable resident limit under this sub-
24 paragraph shall be equal to the number of

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

3 “(ii) DISTRIBUTION TO HOSPITALS
4 ALREADY OPERATING OVER RESIDENT
5 LIMIT.—

6 “(I) IN GENERAL.—Subject to
7 subclause (II), in the case of a hos-
8 pital in which the reference resident
9 level of the hospital (as defined in
10 clause (ii)) is greater than the other-
11 wise applicable resident limit, the in-
12 crease in the otherwise applicable resi-
13 dent limit under this subparagraph
14 shall be an amount equal to the prod-
15 uct of the total number of additional
16 residency positions available for dis-
17 tribution under subparagraph (A)(ii)
18 and the quotient of—

19 “(aa) the number of resident
20 positions by which the reference
21 resident level of the hospital ex-
22 ceeds the otherwise applicable
23 resident limit for the hospital;
24 and

1 “(bb) the number of resident
2 positions by which the reference
3 resident level of all such hospitals
4 with respect to which an applica-
5 tion is approved under this sub-
6 paragraph exceeds the otherwise
7 applicable resident limit for such
8 hospitals.

9 “(II) REQUIREMENTS.—A hos-
10 pital described in subclause (I)—

11 “(aa) is not eligible for an
12 increase in the otherwise applica-
13 ble resident limit under this sub-
14 paragraph unless the amount by
15 which the reference resident level
16 of the hospital exceeds the other-
17 wise applicable resident limit is
18 not less than 10 and the hospital
19 trains at least 25 percent of the
20 full-time equivalent residents of
21 the hospital in primary care and
22 general surgery (as of the date of
23 enactment of this paragraph);
24 and

1 “(bb) shall continue to train
2 at least 25 percent of the full-
3 time equivalent residents of the
4 hospital in primary care and gen-
5 eral surgery for the 10-year pe-
6 riod beginning on such date.

7 In the case where the Secretary deter-
8 mines that a hospital no longer meets
9 the requirement of item (bb), the Sec-
10 retary may reduce the otherwise appli-
11 cable resident limit of the hospital by
12 the amount by which such limit was
13 increased under this clause.

14 “(III) CLARIFICATION REGARD-
15 ING ELIGIBILITY FOR OTHER ADDI-
16 TIONAL RESIDENCY POSITIONS.—
17 Nothing in this clause shall be con-
18 strued as preventing a hospital de-
19 scribed in subclause (I) from applying
20 for additional residency positions
21 under this paragraph that are not re-
22 served for distribution under this
23 clause.

24 “(iii) REFERENCE RESIDENT
25 LEVEL.—

1 “(I) IN GENERAL.—Except as
2 otherwise provided in subclause (II),
3 the reference resident level specified in
4 this clause for a hospital is the resi-
5 dent level for the most recent cost re-
6 porting period of the hospital ending
7 on or before the date of enactment of
8 this paragraph, for which a cost re-
9 port has been settled (or, if not, sub-
10 mitted (subject to audit)), as deter-
11 mined by the Secretary.

12 “(II) USE OF MOST RECENT AC-
13 COUNTING PERIOD TO RECOGNIZE EX-
14 PANSION OF EXISTING PROGRAM OR
15 ESTABLISHMENT OF NEW PRO-
16 GRAM.—If a hospital submits a timely
17 request to increase its resident level
18 due to an expansion of an existing
19 residency training program or the es-
20 tablishment of a new residency train-
21 ing program that is not reflected on
22 the most recent cost report that has
23 been settled (or, if not, submitted
24 (subject to audit)), after audit and
25 subject to the discretion of the Sec-

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

7 “(C) CONSIDERATIONS IN REDISTRIBU-
8 TION.—In determining for which hospitals the
9 increase in the otherwise applicable resident
10 limit is provided under subparagraph (B) (other
11 than an increase under subparagraph (B)(ii)),
12 the Secretary shall take into account the dem-
13 onstrated likelihood of the hospital filling the
14 positions within the first 3 cost reporting peri-
15 ods beginning on or after July 1, 2010, made
16 available under this paragraph, as determined
17 by the Secretary.

18 “(D) PRIORITY FOR CERTAIN AREAS.—In
19 determining for which hospitals the increase in
20 the otherwise applicable resident limit is pro-
21 vided under subparagraph (B) (other than an
22 increase under subparagraph (B)(ii)), the Sec-
23 retary shall distribute the increase to hospitals
24 based on the following criteria:

1 “(i) The Secretary shall give pref-
2 erence to hospitals that submit applica-
3 tions for new primary care and general
4 surgery residency positions. In the case of
5 any increase based on such preference, a
6 hospital shall ensure that—

7 “(I) the position made available
8 as a result of such increase remains a
9 primary care or general surgery resi-
10 dency position for not less than 10
11 years after the date on which the posi-
12 tion is filled; and

13 “(II) the total number of primary
14 care and general surgery residency po-
15 sitions in the hospital (determined
16 based on the number of such positions
17 as of the date of such increase, includ-
18 ing any position added as a result of
19 such increase) is not decreased during
20 such 10-year period.

21 In the case where the Secretary determines
22 that a hospital no longer meets the re-
23 quirement of subclause (II), the Secretary
24 may reduce the otherwise applicable resi-
25 dent limit of the hospital by the amount by

1 which such limit was increased under this
2 paragraph.

3 “(ii) The Secretary shall give pref-
4 erence to hospitals that emphasizes train-
5 ing in community health centers and other
6 community-based clinical settings.

7 “(iii) The Secretary shall give pref-
8 erence to hospitals in States that have
9 more medical students than residency posi-
10 tions available (including a greater pref-
11 erence for those States with smaller resi-
12 dent-to-medical-student ratios). In deter-
13 mining the number of medical students in
14 a State for purposes of the preceding sen-
15 tence, the Secretary shall include planned
16 students at medical schools which have
17 provisional accreditation by the Liaison
18 Committee on Medical Education or the
19 American Osteopathic Association.

20 “(iv) The Secretary shall give pref-
21 erence to hospitals in States that have low
22 resident-to-population ratios (including a
23 greater preference for those States with
24 lower resident-to-population ratios).

25 “(E) LIMITATION.—

1 “(i) IN GENERAL.—Except as pro-
2 vided in clause (ii), in no case may a hos-
3 pital (other than a hospital described in
4 subparagraph (B)(ii)(I), subject to the lim-
5 itation under subparagraph (B)(ii)(III))
6 apply for more than 50 full-time equivalent
7 additional residency positions under this
8 paragraph.

9 “(ii) INCREASE IN NUMBER OF ADDI-
10 TIONAL POSITIONS AVAILABLE FOR DIS-
11 TRIBUTION.—The Secretary shall increase
12 the number of full-time equivalent addi-
13 tional residency positions a hospital may
14 apply for under this paragraph if the Sec-
15 retary determines that the number of addi-
16 tional residency positions available for dis-
17 tribution under subparagraph (A)(ii) ex-
18 ceeds the number of such applications ap-
19 proved.

20 “(F) APPLICATION OF PER RESIDENT
21 AMOUNTS FOR PRIMARY CARE AND NONPRI-
22 MARY CARE.—With respect to additional resi-
23 dency positions in a hospital attributable to the
24 increase provided under this paragraph, the ap-
25 proved FTE resident amounts are deemed to be

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

4 “(G) DISTRIBUTION.—The Secretary shall
5 distribute the increase to hospitals under this
6 paragraph not later than 2 years after the date
7 of enactment of this paragraph.”.

8 (b) IME.—

9 (1) IN GENERAL.—Section 1886(d)(5)(B)(v) of
10 the Social Security Act (42 U.S.C.
11 1395ww(d)(5)(B)(v)), in the second sentence, is
12 amended—

13 (A) by striking “subsection (h)(7)” and in-
14 serting “subsections (h)(7) and (h)(8)”; and

15 (B) by striking “it applies” and inserting
16 “they apply”.

17 (2) CONFORMING PROVISION.—Section
18 1886(d)(5)(B) of the Social Security Act (42 U.S.C.
19 1395ww(d)(5)(B)) is amended by adding at the end
20 the following clause:

21 “(x) For discharges occurring on or after the
22 date of enactment of this clause, insofar as an addi-
23 tional payment amount under this subparagraph is
24 attributable to resident positions distributed to a
25 hospital under subsection (h)(8)(B), the indirect

1 teaching adjustment factor shall be computed in the
2 same manner as provided under clause (ii) with re-
3 spect to such resident positions.”.

4 **SEC. 327. COUNTING RESIDENT TIME IN OUTPATIENT SET-**
5 **TINGS.**

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

8 (1) by striking “under an approved medical
9 residency training program”; and

10 (2) by striking “if the hospital incurs all, or
11 substantially all, of the costs for the training pro-
12 gram in that setting” and inserting “if the hospital
13 continues to incur the costs of the stipends and
14 fringe benefits of the resident during the time the
15 resident spends in that setting”.

16 (b) IME.—Section 1886(d)(5)(B)(iv) of the Social
17 Security Act (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amend-
18 ed—

19 (1) by striking “under an approved medical
20 residency training program”; and

21 (2) by striking “if the hospital incurs all, or
22 substantially all, of the costs for the training pro-
23 gram in that setting” and inserting “if the hospital
24 continues to incur the costs of the stipends and

1 fringe benefits of the intern or resident during the
2 time the intern or resident spends in that setting”.

3 (c) EFFECTIVE DATES; APPLICATION.—

4 (1) IN GENERAL.—Effective for cost reporting
5 periods beginning on or after July 1, 2009, the Sec-
6 retary of Health and Human Services shall imple-
7 ment the amendments made by this section in a
8 manner so as to apply to cost reporting periods be-
9 ginning on or after July 1, 2009.

10 (2) APPLICATION.—The amendments made by
11 this section shall not be applied in a manner that re-
12 quires reopening of any settled hospital cost reports
13 as to which there is not a jurisdictionally proper ap-
14 peal pending as of the date of the enactment of this
15 Act on the issue of payment for indirect costs of
16 medical education under section 1886(d)(5)(B) of
17 the Social Security Act (42 U.S.C.
18 1395ww(d)(5)(B)) or for direct graduate medical
19 education costs under section 1886(h) of such Act
20 (42 U.S.C. 1395ww(h)).

1 **SEC. 328. RULES FOR COUNTING RESIDENT TIME FOR DI-**
2 **DACTIC AND SCHOLARLY ACTIVITIES AND**
3 **OTHER ACTIVITIES.**

4 (a) GME.—Section 1886(h) of the Social Security
5 Act (42 U.S.C. 1395ww(h)), as amended by section
6 327(a), is amended—

7 (1) in paragraph (4)(E)—

8 (A) by designating the first sentence as a
9 clause (i) with the heading “IN GENERAL” and
10 appropriate indentation and by striking “Such
11 rules” and inserting “Subject to clause (ii),
12 such rules”; and

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

15 “(ii) TREATMENT OF CERTAIN NON-
16 HOSPITAL AND DIDACTIC ACTIVITIES.—
17 Such rules shall provide that all time spent
18 by an intern or resident in an approved
19 medical residency training program in a
20 nonhospital setting that is primarily en-
21 gaged in furnishing patient care (as de-
22 fined in paragraph (5)(K)) in non-patient
23 care activities, such as didactic conferences
24 and seminars, but not including research
25 not associated with the treatment or diag-
26 nosis of a particular patient, as such time

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

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

6 “(I) In determining the hospital’s number
7 of full-time equivalent residents for purposes of
8 this subsection, all the time that is spent by an
9 intern or resident in an approved medical resi-
10 dency training program on vacation, sick leave,
11 or other approved leave, as such time is defined
12 by the Secretary, and that does not prolong the
13 total time the resident is participating in the
14 approved program beyond the normal duration
15 of the program shall be counted toward the de-
16 termination of full-time equivalency.”; and

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

19 “(M) NONHOSPITAL SETTING THAT IS PRI-
20 MARILY ENGAGED IN FURNISHING PATIENT
21 CARE.—The term ‘nonhospital setting that is
22 primarily engaged in furnishing patient care’
23 means a nonhospital setting in which the pri-
24 mary activity is the care and treatment of pa-
25 tients, as defined by the Secretary.”.

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

5 “(xi)(I) The provisions of subparagraph (I) of
6 subsection (h)(4) shall apply under this subpara-
7 graph in the same manner as they apply under such
8 subsection.

9 “(II) In determining the hospital’s number of
10 full-time equivalent residents for purposes of this
11 subparagraph, all the time spent by an intern or
12 resident in an approved medical residency training
13 program in non-patient care activities, such as di-
14 dactic conferences and seminars, as such time and
15 activities are defined by the Secretary, that occurs in
16 the hospital shall be counted toward the determina-
17 tion of full-time equivalency if the hospital—

18 “(aa) is recognized as a subsection (d) hos-
19 pital;

20 “(bb) is recognized as a subsection (d)
21 Puerto Rico hospital;

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

24 “(dd) is a provider-based hospital out-
25 patient department.

1 “(III) In determining the hospital’s number of
2 full-time equivalent residents for purposes of this
3 subparagraph, all the time spent by an intern or
4 resident in an approved medical residency training
5 program in research activities that are not associ-
6 ated with the treatment or diagnosis of a particular
7 patient, as such time and activities are defined by
8 the Secretary, shall not be counted toward the deter-
9 mination of full-time equivalency.”.

10 (c) EFFECTIVE DATES; APPLICATION.—

11 (1) IN GENERAL.—Except as otherwise pro-
12 vided, the Secretary of Health and Human Services
13 shall implement the amendments made by this sec-
14 tion in a manner so as to apply to cost reporting pe-
15 riods beginning on or after January 1, 1983.

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

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

1 (4) APPLICATION.—The amendments made by
 2 this section shall not be applied in a manner that re-
 3 quires reopening of any settled hospital cost reports
 4 as to which there is not a jurisdictionally proper ap-
 5 peal pending as of the date of the enactment of this
 6 Act on the issue of payment for indirect costs of
 7 medical education under section 1886(d)(5)(B) of
 8 the Social Security Act or for direct graduate med-
 9 ical education costs under section 1886(h) of such
 10 Act.

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

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

16 “(vi) REDISTRIBUTION OF RESIDENCY
 17 SLOTS AFTER A HOSPITAL CLOSES.—

18 “(I) IN GENERAL.—Subject to
 19 the succeeding provisions of this
 20 clause, the Secretary shall, by regula-
 21 tion, establish a process under which,
 22 in the case where a hospital with an
 23 approved medical residency program
 24 closes on or after the date of enact-
 25 ment of the Balanced Budget Act of

1 1997, the Secretary shall increase the
2 otherwise applicable resident limit
3 under this paragraph for other hos-
4 pitals in accordance with this clause.

5 “(II) PRIORITY FOR HOSPITALS
6 IN CERTAIN AREAS.—Subject to the
7 succeeding provisions of this clause, in
8 determining for which hospitals the
9 increase in the otherwise applicable
10 resident limit is provided under such
11 process, the Secretary shall distribute
12 the increase to hospitals located in the
13 following priority order (with pref-
14 erence given within each category to
15 hospitals that are members of the
16 same affiliated group (as defined by
17 the Secretary under clause (ii)) as the
18 closed hospital):

19 “(aa) First, to hospitals lo-
20 cated in the same core-based sta-
21 tistical area as, or a core-based
22 statistical area contiguous to, the
23 hospital that closed.

1 “(bb) Second, to hospitals
2 located in the same State as the
3 hospital that closed.

4 “(cc) Third, to hospitals lo-
5 cated in the same region of the
6 country as the hospital that
7 closed.

8 “(dd) Fourth, to all other
9 hospitals.

10 “(III) REQUIREMENT HOSPITAL
11 LIKELY TO FILL POSITION WITHIN
12 CERTAIN TIME PERIOD.—The Sec-
13 retary may only increase the otherwise
14 applicable resident limit of a hospital
15 under such process if the Secretary
16 determines the hospital has dem-
17 onstrated a likelihood of filling the po-
18 sitions made available under this
19 clause within 3 years.

20 “(IV) LIMITATION.—The aggre-
21 gate number of increases in the other-
22 wise applicable resident limits for hos-
23 pitals under this clause shall be equal
24 to the number of resident positions in
25 the approved medical residency pro-

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

3 “(vii) SPECIAL RULE FOR ACQUIRED
4 HOSPITALS.—

5 “(I) IN GENERAL.—In the case
6 of a hospital that is acquired (through
7 any mechanism) by another entity
8 with the approval of a bankruptcy
9 court, during a period determined by
10 the Secretary (but not less than 3
11 years), the applicable resident limit of
12 the acquired hospital shall, except as
13 provided in subclause (II), be the ap-
14 plicable resident limit of the hospital
15 that was acquired (as of the date im-
16 mediately before the acquisition),
17 without regard to whether the acquir-
18 ing entity accepts assignment of the
19 Medicare provider agreement of the
20 hospital that was acquired, so long as
21 the acquiring entity continues to oper-
22 ate the hospital that was acquired and
23 to furnish services, medical residency
24 programs, and volume of patients
25 similar to the services, medical resi-

1 dency programs, and volume of pa-
2 tients of the hospital that was ac-
3 quired (as determined by the Sec-
4 retary) during such period.

5 “(II) LIMITATION.—Subclause
6 (I) shall only apply in the case where
7 an acquiring entity waives the right as
8 a new provider under the program
9 under this title to have the otherwise
10 applicable resident limit of the ac-
11 quired hospital re-established or in-
12 creased.”.

13 (b) IME.—Section 1886(d)(5)(B)(v) of the Social Se-
14 curity Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the second
15 sentence, as amended by section 326(b), is amended by
16 striking “subsections (h)(7) and (h)(8)” and inserting
17 “subsections (h)(4)(H)(vi), (h)(4)(H)(vii), (h)(7), and
18 (h)(8)”.

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

1 1395ww(d)(5)(B)) or for direct graduate medical edu-
 2 cation costs under section 1886(h) of such Act (42 U.S.C.
 3 1395ww(h)).

4 (d) NO AFFECT ON TEMPORARY FTE CAP ADJUST-
 5 MENTS.—The amendments made by this section shall not
 6 affect any temporary adjustment to a hospital’s FTE cap
 7 under section 413.79(h) of title 42, Code of Federal Regu-
 8 lations (as in effect on the date of enactment of this Act).

9 **SEC. 330. QUALITY IMPROVEMENT ORGANIZATION ASSIST-**
 10 **ANCE FOR PHYSICIAN PRACTICES SEEKING**
 11 **TO BE PATIENT CENTERED MEDICAL HOME**
 12 **PRACTICES.**

13 Not later than 90 days after the date of enactment
 14 of this Act, the Secretary of Health and Human Services
 15 shall revise the 9th Statement of Work under the Quality
 16 Improvement Program under part B of title XI of the So-
 17 cial Security Act to include a requirement that, in order
 18 to be an eligible Quality Improvement Organization (in
 19 this section referred to as a “QIO”) for the 9th Statement
 20 of Work contract cycle, a QIO shall provide assistance,
 21 including technical assistance, to physicians under the
 22 Medicare program under title XVIII of the Social Security
 23 Act that seek to acquire the elements necessary to be rec-
 24 ognized as a patient centered medical home practice under
 25 the National Committee for Quality Assurance’s Physician

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

3 **TITLE IV—STUDIES**

4 **SEC. 401. STUDY CONCERNING THE DESIGNATION OF PRI-** 5 **MARY CARE AS A SHORTAGE PROFESSION.**

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

11 (1) a description of the criteria for the designa-
12 tion of primary care physicians as professions in
13 shortage as defined by the Secretary under section
14 212(a)(5)(A) of the Immigration and Nationality
15 Act;

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

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

1 (b) REQUIREMENTS.—In conducting the study under
2 subsection (a), the Secretary of Labor shall consider work-
3 force data from the Health Resources and Services Admin-
4 istration, the Council on Graduate Medical Education, the
5 Association of American Medical Colleges, and input from
6 physician membership organizations that represent pri-
7 mary care physicians.

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

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

16 (b) REPORT.—

17 (1) SUBMISSION AND DISSEMINATION OF RE-
18 PORT.—Not later than 1 year after the date of en-
19 actment of this Act, the Comptroller General shall
20 submit a report on the study required by subsection
21 (a) to the Committee on Health, Education, Labor,
22 and Pensions of the Senate and the Committee on
23 Education and Labor of the House of Representa-
24 tives, and shall make such report widely available to
25 the public.

