

111TH CONGRESS
1ST SESSION

H. R. 2350

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 HOUSE OF REPRESENTATIVES

MAY 12, 2009

Ms. SCHWARTZ (for herself, Mr. ABERCROMBIE, Ms. BERKLEY, Mr. BERMAN, Mr. BISHOP of New York, Mr. BLUMENAUER, Mr. BOSWELL, Mr. BRADY of Pennsylvania, Mrs. CAPPES, Mr. CARNAHAN, Ms. CASTOR of Florida, Mrs. CHRISTENSEN, Ms. CLARKE, Mr. CLEAVER, Mr. COHEN, Mr. CONNOLLY of Virginia, Mr. COURTNEY, Mr. CROWLEY, Mr. CUELLAR, Mr. DAVIS of Illinois, Ms. DELAURO, Mr. DOGGETT, Mr. DRIEHAUS, Mr. EDWARDS of Texas, Mr. ELLISON, Mr. FARR, Mr. FATTAH, Ms. GIFFORDS, Mr. GUTIERREZ, Mrs. HALVORSON, Mr. HARE, Mr. HASTINGS of Florida, Mr. HIGGINS, Mr. HINCHEY, Ms. HIRONO, Mr. HOLT, Mr. ISRAEL, Ms. JACKSON-LEE of Texas, Ms. KAPTUR, Mr. KENNEDY, Ms. KILROY, Mr. KIND, Mr. KUCINICH, Ms. LEE of California, Mr. LEVIN, Mr. LEWIS of Georgia, Mr. LOEBSACK, Mr. MAFFEI, Ms. MATSUI, Ms. MCCOLLUM, Mr. McDERMOTT, Mr. MCGOVERN, Ms. MOORE of Wisconsin, Mr. MORAN of Virginia, Mr. PATRICK J. MURPHY of Pennsylvania, Mr. MURTHA, Mrs. NAPOLITANO, Mr. NEAL of Massachusetts, Mr. OLVER, Mr. PERLMUTTER, Mr. PETERS, Ms. PINGREE of Maine, Mr. SALAZAR, Mr. SCHRADER, Mr. SCOTT of Virginia, Mr. SCOTT of Georgia, Ms. SHEA-PORTER, Mr. SIRES, Mr. SNYDER, Mr. VAN HOLLEN, Ms. WATERS, Ms. WATSON, Mr. WEINER, Mr. WILSON of Ohio, Mr. YARMUTH, Mr. MEEKS of New York, Ms. LINDA T. SÁNCHEZ of California, Mr. HONDA, Mr. ETHERIDGE, Ms. SUTTON, Mr. HOLDEN, Mr. KANJORSKI, Mr. LANGEVIN, Mr. LARSON of Connecticut, Mr. DOYLE, Mr. WEXLER, and Ms. DEGETTE) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means and Education and Labor, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To 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 assistance, 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,

1 compared to a 5 percent departure rate for those
2 who were certified in subspecialties of internal medi-
3 cine.

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

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

11 (4) In 2006, only 24 percent of third-year inter-
12 nal medicine resident intended to pursue careers in
13 general internal medicine, down from 54 percent in
14 1998.

15 (5) Primary care physicians and primary care
16 providers serve as the point of first contact for most
17 patients and are able to coordinate the care of the
18 whole person, reducing unnecessary care and dupli-
19 cative testing.

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

1 (7) Patients with primary care physicians or
2 primary care providers have lower health care ex-
3 penditures and primary care is correlated with better
4 health status, lower overall mortality, and longer life
5 expectancy.

6 (8) Higher proportions of primary care physi-
7 cians are associated with significantly reduced utili-
8 zation.

9 (9) The United States has a higher ratio of spe-
10 cialists to primary care physicians than other indus-
11 trialized nations and the population of the United
12 States is growing faster than the expected rate of
13 growth in the supply of primary care physicians.

14 (10) The number of Americans age 65 and
15 older, those eligible for Medicare and who use far
16 more ambulatory care visits per person as those
17 under age 65, is expected to double from 2000 to
18 2030.

19 (11) A decrease in Federal spending to carry
20 out programs authorized by title VII of the Public
21 Health Service Act threatens the viability of one of
22 the programs used to solve the problem of inad-
23 equate access to primary care.

24 (12) The National Health Service Corps pro-
25 gram has a proven record of supplying physicians to

1 underserved areas, and has played an important role
2 in expanding access for underserved populations in
3 rural and inner city communities.

4 (13) Individuals in many geographic areas, es-
5 pecially rural areas, lack adequate access to high
6 quality preventive, primary health care, contributing
7 to significant health disparities that impair Amer-
8 ica’s public health and economic productivity.

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

12 **SEC. 3. DEFINITIONS.**

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

14 (1) CHRONIC CARE COORDINATION.—The term
15 “chronic care coordination” means the coordination
16 of services that is based on the Chronic Care Model
17 that provides on-going health care to patients with
18 chronic diseases that may include any of the fol-
19 lowing services:

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

23 (B) The management of, and referral for,
24 medical and other health services, including

1 interdisciplinary care conferences and manage-
2 ment with other providers.

3 (C) The monitoring and management of
4 medications.

5 (D) Patient education and counseling serv-
6 ices.

7 (E) Family caregiver education and coun-
8 seling services.

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

12 (G) Providing access by telephone with
13 physicians and other appropriate health care
14 professionals, including 24-hour availability of
15 such professionals for emergencies.

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

18 (I) Managing and facilitating transitions
19 among health care professionals and across set-
20 tings of care, including the following:

21 (i) Pursuing the treatment option
22 elected by the individual.

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

1 (J) Information about, and referral to,
2 hospice care, including patient and family care-
3 giver education and counseling about hospice
4 care, and facilitating transition to hospice care
5 when elected.

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

8 (2) CRITICAL SHORTAGE HEALTH FACILITY.—
9 The term “critical shortage health facility” means a
10 public or private nonprofit health facility that does
11 not serve a health professional shortage area (as
12 designated under section 332 of the Public Health
13 Service Act), but that has a critical shortage of phy-
14 sicians (as determined by the Secretary) in a pri-
15 mary care field.

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

19 (4) PRIMARY CARE.—The term “primary care”
20 means the provision of integrated, high-quality, ac-
21 cessible health care services by health care providers
22 who are accountable for addressing a full range of
23 personal health and health care needs, developing a
24 sustained partnership with patients, practicing in

1 the context of family and community, and working
2 to minimize disparities across population subgroups.

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

5 (A) The field of family medicine.

6 (B) The field of general internal medicine.

7 (C) The field of geriatric medicine.

8 (D) The field of pediatric medicine

9 (6) PRIMARY CARE PHYSICIAN.—The term “pri-
10 mary care physician” means a physician who is
11 trained in a primary care field who provides first
12 contact, continuous, and comprehensive care to pa-
13 tients.

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

16 (A) a nurse practitioner; or

17 (B) a physician assistant practicing as a
18 member of a physician-directed or nurse-practi-
19 tioner-directed team;

20 who provides first contact, continuous, and com-
21 prehensive care to patients.

22 (8) PRINCIPAL CARE.—The term “principal
23 care” means integrated, accessible health care that
24 is provided by a physician who is a medical sub-
25 specialist that addresses the majority of the personal

1 health care needs of patients with chronic conditions
2 requiring the subspecialist’s expertise, and for whom
3 the subspecialist assumes care management, devel-
4 oping a sustained physician-patient partnership and
5 practicing within the context of family and commu-
6 nity.

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

9 (b) PRIMARY MEDICAL CARE SHORTAGE AREA.—

10 (1) IN GENERAL.—In this Act, the term “pri-
11 mary medical care shortage area” or “PMCSA”
12 means a geographic area with a shortage of physi-
13 cians (as designated by the Secretary) in a primary
14 care field, as designated in accordance with para-
15 graph (2).

16 (2) DESIGNATION.—To be designated by the
17 Secretary as a PMCSA, the Secretary must find
18 that the geographic area involved has an established
19 shortage of primary care physicians for the popu-
20 lation served. The Secretary shall make such a des-
21 ignation with respect to an urban or rural geo-
22 graphic area if the following criteria are met:

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

1 (B) One of the following conditions pre-
2 vails within the area:

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

6 (ii) The area has a population to full-
7 time-equivalent primary care physician
8 ratio of less than 3,500 to 1 and has un-
9 usually high needs for primary care serv-
10 ices or insufficient capacity of existing pri-
11 mary care providers.

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

14 (c) MEDICALLY UNDERSERVED AREA.—

15 (1) IN GENERAL.—In this Act, the term “medi-
16 cally underserved area” or “MUA” means a rational
17 service area with a demonstrable shortage of pri-
18 mary health care resources relative to the needs of
19 the entire population within the service area as de-
20 termined in accordance with paragraph (2) through
21 the use of the Index of Medical Underservice (re-
22 ferred to in this subsection as the “IMU”) with re-
23 spect to data on a service area.

24 (2) DETERMINATIONS.—Under criteria to be
25 established by the Secretary with respect to the

1 IMU, if a service area is determined by the Sec-
2 retary to have a score of 62.0 or less, such area shall
3 be eligible to be designated as a MUA.

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

7 (A) The ratio of primary medical care phy-
8 sicians per 1,000 individuals in the population
9 of the area involved.

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

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

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

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

20 (d) PATIENT CENTERED MEDICAL HOME.—

21 (1) IN GENERAL.—In this Act, the term “pa-
22 tient centered medical home” means a physician-di-
23 rected practice (or a nurse-practitioner-directed
24 practice in those States in which such functions are
25 included in the scope of practice of licensed nurse

1 practitioners) that has been certified by an organiza-
2 tion under paragraph (3) as meeting the following
3 standards:

4 (A) The practice provides patients who
5 elect to obtain care through a patient centered
6 medical home (referred to as “participating pa-
7 tients”) with direct and ongoing access to a pri-
8 mary or principal care physician or nurse prac-
9 titioner who accepts responsibility for providing
10 first contact, continuous, and comprehensive
11 care to the whole person, in collaboration with
12 teams of other health professionals, including
13 nurses and specialist physicians, as needed and
14 appropriate.

15 (B) The practice applies standards for ac-
16 cess to care and communication with partici-
17 pating beneficiaries.

18 (C) The practice has readily accessible,
19 clinically useful information on participating pa-
20 tients that enables the practice to treat such
21 patients comprehensively and systematically.

22 (D) The practice maintains continuous re-
23 lationships with participating patients by imple-
24 menting evidence-based guidelines and applying
25 such guidelines to the identified needs of indi-

1 vidual beneficiaries over time and with the in-
2 tensity needed by such beneficiaries.

3 (2) RECOGNITION OF NCQA APPROVAL.—Such
4 term also includes a physician-directed (or nurse-
5 practitioner-directed) practice that has been recog-
6 nized as a medical home through the Physician
7 Practice Connections—patient centered Medical
8 Home (“PPC–PCMH”) voluntary recognition proc-
9 ess of the National Committee for Quality Assur-
10 ance.

11 (3) STANDARD SETTING AND QUALIFICATION
12 PROCESS FOR MEDICAL HOMES.—The Secretary
13 shall establish a process for the selection of a quali-
14 fied standard setting and certification organiza-
15 tion—

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

19 (B) to provide for the review and certifi-
20 cation of medical practices as meeting such
21 standards.

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

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

3 (B) the nurse practitioner is acting con-
4 sistently with State law.

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

10 **TITLE I—MEDICAL EDUCATION**

11 **SEC. 101. RECRUITMENT INCENTIVES.**

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

15 **“PART F—MEDICAL EDUCATION RECRUITMENT** 16 **INCENTIVES**

17 **“SEC. 786. MEDICAL EDUCATION RECRUITMENT INCEN-** 18 **TIVES.**

19 “(a) IN GENERAL.—The Secretary is authorized to
20 award grants or contracts to institutions of higher edu-
21 cation that are graduate medical schools, to enable the
22 graduate medical schools to improve primary care edu-
23 cation and training for medical students.

24 “(b) APPLICATION.—A graduate medical school that
25 desires to receive a grant under this section shall submit

1 to the Secretary an application at such time, in such man-
2 ner, and containing such information as the Secretary may
3 require.

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

7 “(1) The creation of primary care mentorship
8 programs.

9 “(2) Curriculum development for population-
10 based primary care models of care, such as the pa-
11 tient centered medical home.

12 “(3) Increased opportunities for ambulatory,
13 community-based training.

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

17 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
18 is authorized to be appropriated to carry out this section
19 \$50,000,000 for each of the fiscal years 2010 through
20 2012.”.

21 **SEC. 102. DEBT FORGIVENESS, SCHOLARSHIPS, AND SERV-**
22 **ICE OBLIGATIONS.**

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

1 (b) AMENDMENT TO THE PUBLIC HEALTH SERVICE
2 ACT.—Part D of title III of the Public Health Service Act
3 (42 U.S.C. 254b et seq.) is amended by adding at the end
4 the following:

5 **“Subpart XI—Primary Care Medical Education**

6 **“SEC. 340I. SCHOLARSHIPS.**

7 “(a) IN GENERAL.—The Secretary, acting through
8 the Administrator of the Health Resources and Services
9 Administration, shall award grants to critical shortage
10 health facilities to enable such facilities to provide scholar-
11 ships to individuals who agree to serve as physicians at
12 such facilities after completing a residency in a primary
13 care field (as defined in section 3(a)(5) of the Preserving
14 Patient Access to Primary Care Act of 2009).

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

18 “(1) the facility agrees to provide the individual
19 with a scholarship for each school year (not to ex-
20 ceed 4 school years) in which the individual is en-
21 rolled as a full-time student in a school of medicine
22 or a school of osteopathic medicine; and

23 “(2) the individual agrees—

24 “(A) to maintain an acceptable level of
25 academic standing;

1 “(B) to complete a residency in a primary
2 care field; and

3 “(C) after completing the residency, to
4 serve as a primary care physician at such facil-
5 ity in such field for a time period equal to the
6 greater of—

7 “(i) one year for each school year for
8 which the individual was provided a schol-
9 arship under this section; or

10 “(ii) two years.

11 “(c) AMOUNT.—

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

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

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

1 “(d) APPLICATION OF CERTAIN PROVISIONS.—The
2 provisions of subpart III of part D shall, except as incon-
3 sistent with this section, apply to the program established
4 in subsection (a) in the same manner and to the same
5 extent as such provisions apply to the National Health
6 Service Corps Scholarship Program established in such
7 subpart.

8 “(e) DEFINITIONS.—In this section:

9 “(1) CRITICAL SHORTAGE HEALTH FACILITY.—
10 The term ‘critical shortage health facility’ means a
11 public or private nonprofit health facility that does
12 not serve a health professional shortage area (as
13 designated under section 332), but has a critical
14 shortage of physicians (as determined by the Sec-
15 retary) in a primary care field.

16 “(2) ELIGIBLE INDIVIDUAL.—The term ‘eligible
17 individual’ means an individual who is enrolled, or
18 accepted for enrollment, as a full-time student in an
19 accredited school of medicine or school of osteo-
20 pathic medicine.

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

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

1 “(b) LOAN REPAYMENTS.—The Secretary, acting
2 through the Administrator of the Health Resources and
3 Services Administration, shall establish a program of en-
4 tering into contracts with eligible individuals under
5 which—

6 “(1) the individual agrees to serve—

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

9 “(B) in an area that is not a health profes-
10 sional shortage area (as designated under sec-
11 tion 332), but has a critical shortage of primary
12 care physicians and primary care providers (as
13 determined by the Secretary) in such field; and

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

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

24 “(d) APPLICATION OF CERTAIN PROVISIONS.—The
25 provisions of subpart III of part D shall, except as incon-

1 sistent with this section, apply to the program established
2 in subsection (a) in the same manner and to the same
3 extent as such provisions apply to the National Health
4 Service Corps Scholarship Program established in such
5 subpart.

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

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

10 “(2) a nurse practitioner.

11 **“SEC. 340K. LOAN REPAYMENTS FOR PHYSICIANS IN THE**
12 **FIELDS OF OBSTETRICS AND GYNECOLOGY**
13 **AND CERTIFIED NURSE MIDWIVES.**

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

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

22 “(1) the individual agrees to serve—

23 “(A) as a physician in the field of obstet-
24 rics and gynecology or as a certified nurse mid-
25 wife; 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 physi-
4 cians in the fields of obstetrics and gynecology
5 or certified nurse midwives (as determined by
6 the Secretary), respectively; and

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

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

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

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

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

3 “(2) a certified nurse midwife.

4 **“SEC. 340L. REPORTS.**

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

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

12 “(2) the number of graduates;

13 “(3) the amount of scholarship payments and
14 loan repayments made;

15 “(4) which educational institution the recipients
16 attended;

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

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

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

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

1 “(9) the demographics of the individuals par-
2 ticipating in the scholarship and loan repayment
3 programs;

4 “(10) the justification for the allocation of
5 funds between the scholarship and loan repayment
6 programs; and

7 “(11) an evaluation of the overall costs and
8 benefits of the programs.

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

10 “To carry out sections 340I, 340J, and 340K there
11 are authorized to be appropriated \$55,000,000 for fiscal
12 year 2010, \$90,000,000 for fiscal year 2011, and
13 \$125,000,000 for fiscal year 2012, to be used solely for
14 scholarships and loan repayment awards for primary care
15 physicians and primary care providers.”.

16 **SEC. 103. DEFERMENT OF LOANS DURING RESIDENCY AND**
17 **INTERNSHIPS.**

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

1 (b) FFEL LOANS.—Section 428(b)(1)(M)(i) of the
2 Higher Education Act of 1965 (20 U.S.C.
3 1078(b)(1)(M)(i)) is amended by inserting “unless the
4 medical internship or residency program is 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)” after “resi-
7 dency program”.

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

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

1 **SEC. 104. EDUCATING MEDICAL STUDENTS ABOUT PRI-**
2 **MARY CARE CAREERS.**

3 Part C of title VII of the Public Health Service Act
4 (42 U.S.C. 293k) is amended by adding at the end the
5 following:

6 **“SEC. 749. EDUCATING MEDICAL STUDENTS ABOUT PRI-**
7 **MARY CARE CAREERS.**

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

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

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

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

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

1 “(d) USE OF FUNDS.—

2 “(1) IN GENERAL.—An entity shall use
3 amounts received under a grant under this section to
4 support State and local campaigns through appro-
5 priate media outlets to promote careers in primary
6 care and to encourage individuals from disadvan-
7 taged backgrounds to enter and pursue careers in
8 primary care.

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

14 “(A) advertise and promote careers in pri-
15 mary care;

16 “(B) promote primary care medical edu-
17 cation programs;

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

20 “(D) highlight individuals in the commu-
21 nity who are practicing primary care physicians;

22 or

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

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

4 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
5 is authorized to be appropriated to carry out this section,
6 such sums as may be necessary for each of fiscal years
7 2010 through 2013.”.

8 **SEC. 105. TRAINING IN A FAMILY MEDICINE, GENERAL IN-**
9 **TERNAL MEDICINE, GENERAL GERIATRICS,**
10 **GENERAL PEDIATRICS, PHYSICIAN ASSIST-**
11 **ANCE, GENERAL DENTISTRY, AND PEDIATRIC**
12 **DENTISTRY.**

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

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

20 **SEC. 106. INCREASED FUNDING FOR NATIONAL HEALTH**
21 **SERVICE CORPS SCHOLARSHIP AND LOAN**
22 **REPAYMENT PROGRAMS.**

23 (a) IN GENERAL.—There is authorized to be appro-
24 priated \$332,000,000 for the period of fiscal years 2010
25 through 2012 for the purpose of carrying out subpart III

1 of part D of title III of the Public Health Service Act
 2 (42 U.S.C. 254l et seq.). Such authorization of appropria-
 3 tions is in addition to the authorization of appropriations
 4 in section 338H of such Act (42 U.S.C. 254q) and any
 5 other authorization of appropriations for such purpose.

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

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

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

17 **TITLE II—MEDICAID RELATED**
 18 **PROVISIONS**

19 **SEC. 201. TRANSFORMATION GRANTS TO SUPPORT PA-**
 20 **TIENT CENTERED MEDICAL HOMES UNDER**
 21 **MEDICAID AND CHIP.**

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

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

1 “(G) Methods for improving the effective-
2 ness and efficiency of medical assistance pro-
3 vided under this title and child health assist-
4 ance provided under title XXI by encouraging
5 the adoption of medical practices that satisfy
6 the standards established by the Secretary
7 under paragraph (2) of section 3(d) of the Pre-
8 serving Patient Access to Primary Care Act of
9 2009 for medical practices to qualify as patient
10 centered medical homes (as defined in para-
11 graph (1) of such section).”;

12 (2) in paragraph (4)—

13 (A) in subparagraph (A)—

14 (i) in clause (i), by striking “and” at
15 the end;

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

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

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

22 (B) in subparagraph (B), by striking the
23 second and third sentences and inserting the
24 following: “Such method shall provide that 100
25 percent of such funds for each of fiscal years

1 2010, 2011, and 2012 shall be allocated among
 2 States that design programs to adopt the inno-
 3 vative methods described in paragraph (2)(G),
 4 with preference given to States that design pro-
 5 grams involving multipayers (including under
 6 title XVIII and private health plans) test
 7 projects for implementation of the elements nec-
 8 essary to be recognized as a patient centered
 9 medical home practice under the National Com-
 10 mittee for Quality Assurance Physicians Prac-
 11 tice Connection—PCMH module (or any other
 12 equivalent process, as determined by the Sec-
 13 retary).”.

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

16 **TITLE III—MEDICARE** 17 **PROVISIONS**

18 **Subtitle A—Primary Care**

19 **SEC. 301. REFORMING PAYMENT SYSTEMS UNDER MEDI-** 20 **CARE TO SUPPORT PRIMARY CARE.**

21 (a) INCREASING BUDGET NEUTRALITY LIMITS
 22 UNDER THE PHYSICIAN FEE SCHEDULE TO ACCOUNT
 23 FOR ANTICIPATED SAVINGS RESULTING FROM PAYMENTS
 24 FOR CERTAIN SERVICES AND THE COORDINATION OF

1 BENEFICIARY CARE.—Section 1848(c)(2)(B) of the Social
2 Security Act (42 U.S.C. 1395w-4(c)(2)(B)) is amended—

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

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

7 “(vii) INCREASE IN LIMITATION TO
8 ACCOUNT FOR CERTAIN ANTICIPATED SAV-
9 INGS.—

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

1 under section 1861(s)(2)(FF) (as de-
2 termined by the Secretary).

3 “(II) MECHANISM TO DETER-
4 MINE APPLICATION OF INCREASE.—
5 The Secretary shall establish a mecha-
6 nism for determining which relative
7 value units established under this
8 paragraph for physicians’ services
9 shall be subject to an adjustment
10 under clause (ii)(I) as a result of the
11 increase under subclause (I).

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

1 tional funds as the Secretary deter-
2 mines are necessary.”.

3 (b) SEPARATE MEDICARE PAYMENT FOR DES-
4 IGNATED PRIMARY CARE SERVICES AND COMPREHENSIVE
5 CARE COORDINATION SERVICES.—

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

9 “(n) PAYMENT FOR DESIGNATED PRIMARY CARE
10 SERVICES AND COMPREHENSIVE CARE COORDINATION
11 SERVICES.—

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

16 “(2) PAYMENT AMOUNT.—The Secretary shall
17 determine the amount of payment for designated
18 primary care services and comprehensive care co-
19 ordination services under this subsection.

20 “(3) DOCUMENTATION REQUIREMENTS.—The
21 Secretary shall propose appropriate documentation
22 requirements to justify payments for designated pri-
23 mary care services and comprehensive care coordina-
24 tion services under this subsection.

25 “(4) DEFINITIONS.—

1 “(A) COMPREHENSIVE CARE COORDINA-
2 TION SERVICES.—The term ‘comprehensive care
3 coordination services’ means care coordination
4 services with procedure codes established by the
5 Secretary (as appropriate) which are furnished
6 to an individual enrolled under this part by a
7 primary care provider or principal care physi-
8 cian.

9 “(B) DESIGNATED PRIMARY CARE SERV-
10 ICES.—The term ‘designated primary care serv-
11 ice’ means a service which the Secretary deter-
12 mines has a procedure code which involves a
13 clinical interaction with an individual enrolled
14 under this part that is inherent to care coordi-
15 nation, including interactions outside of a face-
16 to-face encounter. Such term includes the fol-
17 lowing:

18 “(i) Care plan oversight.

19 “(ii) Evaluation and management pro-
20 vided by phone.

21 “(iii) Evaluation and management
22 provided using internet resources.

23 “(iv) Collection and review of physio-
24 logic data, such as from a remote moni-
25 toring device.

1 “(v) Education and training for pa-
2 tient self management.

3 “(vi) Anticoagulation management
4 services.

5 “(vii) Any other service determined
6 appropriate by the Secretary.”.

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

10 **SEC. 302. COVERAGE OF PATIENT CENTERED MEDICAL**
11 **HOME SERVICES.**

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

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

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

18 (3) by adding at the end the following new sub-
19 paragraph:

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

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

1 “Patient Centered Medical Home Services

2 “(hhh)(1) The term ‘patient centered medical home
3 services’ means care coordination services furnished by a
4 qualified patient centered medical home.

5 “(2) The term ‘qualified patient centered medical
6 home’ means a patient centered medical home (as defined
7 in section 3(d) of the Preserving Patient Access to Pri-
8 mary Care Act of 2009).”.

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

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

15 “(1) MONTHLY FEE.—

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

1 home. Such fee shall be paid on a prospective
2 basis.

3 “(B) CONSIDERATIONS.—The Secretary
4 shall take into account the results of the Medi-
5 care medical home demonstration project under
6 section 204 of the Medicare Improvement and
7 Extension Act of 2006 (42 U.S.C. 1395b–1
8 note; division B of Public Law 109–432) in es-
9 tablishing the payment methodology under sub-
10 paragraph (A).

11 “(2) AMOUNT OF PAYMENT.—

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

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

24 “(ii) Ensuring that the amount of
25 payment is sufficient to support the acqui-

1 sition, use, and maintenance of clinical in-
2 formation systems which—

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

5 “(II) have been shown to facili-
6 tate improved outcomes through care
7 coordination.

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

15 “(B) RISK-ADJUSTMENT.—The Secretary
16 shall use appropriate risk-adjustment in deter-
17 mining the amount of the monthly fee under
18 this paragraph.

19 “(3) FUNDING.—

20 “(A) IN GENERAL.—The Secretary shall
21 determine the aggregate estimated savings for a
22 calendar year as a result of the implementation
23 of this subsection on reducing preventable hos-
24 pital admissions, duplicate testing, medication
25 errors and drug interactions, and other savings

1 under this part and part A (including any sav-
2 ings with respect to items and services for
3 which payment is not made under this section).

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

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

21 “(D) ADDITIONAL FUNDING AS DETER-
22 MINED NECESSARY BY THE SECRETARY.—In
23 addition to any funding made available under
24 subparagraphs (B) and (C), there shall also be
25 available to the Secretary, for purposes of effec-

1 tively implementing this subsection, such addi-
2 tional funds as the Secretary determines are
3 necessary.

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

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

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

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

21 (2) by inserting before the semicolon at the end
22 the following: “, and (X) with respect to patient cen-
23 tered medical home services (as defined in section
24 1861(hhh)(1)), the amount paid shall be (i) in the
25 case of such services which are physicians’ services,

1 the amount determined under subparagraph (N),
2 and (ii) in the case of all other such services, 80 per-
3 cent of the lesser of the actual charge for the service
4 or the amount determined under a fee schedule es-
5 tablished by the Secretary for purposes of this sub-
6 paragraph”.

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

10 **SEC. 303. MEDICARE PRIMARY CARE PAYMENT EQUITY AND**
11 **ACCESS PROVISION.**

12 (a) IN GENERAL.—Section 1848 of the Social Secu-
13 rity Act (42 U.S.C. 1395w-4), as amended by section
14 302(c), is amended by adding at the end the following new
15 subsection:

16 “(q) PRIMARY CARE PAYMENT EQUITY AND AC-
17 CESS.—

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

1 viders, and principal care providers through 1 or
2 more of the following:

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

5 “(B) Service-specific bonus payments.

6 “(C) Any other methodology determined
7 appropriate by the Secretary.

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

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

14 “(B) the specialty of the provider providing
15 the service; and

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

22 “(3) FUNDING.—

23 “(A) DETERMINATION.—The Secretary
24 shall determine the aggregate estimated savings
25 for a calendar year as a result of such increased

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

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

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

23 (b) EFFECTIVE DATE.—The amendment made by
24 this section shall apply to services furnished on or after
25 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 mined by the percentage of Medicare billings per
2 specialty, percentage of Medicare encounters by spe-
3 cialty, or such other measures of relative contribu-
4 tions to patient care as determined by the Secretary;
5 and

6 (B) any changes that may be necessary to re-
7 flect such equitable representation.

8 (4)(A) Whether the existing process, including
9 the application of budget neutrality rules, unfairly
10 disadvantages primary care physicians, primary care
11 providers, or other physicians who principally pro-
12 vide evaluation and management services; and

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

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 **Subtitle B—Preventive Services**

22 **SEC. 311. ELIMINATING TIME RESTRICTION FOR INITIAL** 23 **PREVENTIVE PHYSICAL EXAMINATION.**

24 (a) IN GENERAL.—Section 1862(a)(1)(K) of the So-
25 cial Security Act (42 U.S.C. 1395y(a)(1)(K)) is amended

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 physicians and primary care providers’ services fur-
14 nished on or after January 1, 2010, to an individual
15 with limited English proficiency by a provider, in ad-
16 dition to the amount of payment that would other-
17 wise be made for such services under this part, there
18 shall also be paid an appropriate amount (as deter-
19 mined by the Secretary) in order to recognize the
20 additional time involved in furnishing the service to
21 such individual.

22 “(2) JUDICIAL REVIEW.—There shall be no ad-
23 ministrative or judicial review under section 1869,
24 1878, or otherwise, respecting the determination of
25 the amount of additional payment under this sub-
26 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.

