111TH CONGRESS
1ST SESSION

S. 790

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

IN THE SENATE OF THE UNITED STATES

APRIL 2, 2009

Mr. BINGAMAN (for himself, Mr. CASEY, Mr. KOHL, and Mr. UDALL of New Mexico) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

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

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Access and Health Professions Supply Act of 2009'' or ''HAHPSA 2009''.

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

SEC. 2. FINDINGS.

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

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

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

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

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

(5) Individuals over 65 years of age have twice as many doctor visits as those individuals under 65 years of age, resulting in an increase in the demand for physicians, physician assistants, pharmacists behavioral and mental health professionals, nurses, and dentists.

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

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

who are uninsured have limited access to health care.

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

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

(A) begins and often ends in urban areas;

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

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

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

(10) Health reform must include measures to transform the health delivery system to assure ac-

cess, quality, and efficiency by utilizing contemporary models and venues of care.

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

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

(B) deliver patient-centered care;

(C) practice evidence-based health care;

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

(E) deliver culturally appropriate, personalized care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) In order to respond to forecasted shortages, experts have recommended an increase between 15 and 30 percent in class size at medical schools over the next 10 years.

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

(6) The number of graduates from medical school in the United States who choose to practice family medicine has plummeted 50 percent in less than 10 years. Without congressional intervention,

such decline will likely continue, and access to care in underserved areas will rapidly deteriorate. Family physicians represent 58 percent of the rural physician workforce, 70 percent of non-Federal physicians in whole-county health professional shortage areas, and 78 percent of primary care physician full-time equivalents in the National Health Service Corps.

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

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

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

(10) The Council on Graduate Medical Education's 18th Report (issued in 2007), entitled ''New Paradigms for Physician Training for Improving Access to Health Care'', and 19th Report (issued in 2007), entitled ''Enhancing Flexibility in Graduate

Medical Education'', each call for changes to address the healthcare needs of the United States by removing barriers to expanding and more appropriately training the physician workforce.

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

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

(2) Nurse vacancy rates are currently 8 percent or greater in hospitals and community health centers receiving assistance under section 330 of the Public Health Service Act, and for nursing faculty positions.

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

(4) Nursing baccalaureate and graduate programs rejected more than 40,000 qualified nursing school applicants in 2006, with faculty shortages

identified by such programs as a major reason for turning away qualified applicants.

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

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

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

(8) Geriatric patients receiving care from nurses trained in geriatrics are less frequently readmitted to hospitals or transferred from skilled nursing facilities and nursing facilities to hospitals.

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

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

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

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

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

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

(6) 4 out of 5 current public health workers have not had formal training for their specific job functions.

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

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

(2) Physician assistants always practice medicine as a team with their supervising physicians, however, supervising physicians need not be phys-

ically present when physician assistants provide medical care.

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

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

(5) The National Association of Community Health Centers, the George Washington University, and the Robert Graham Center for Policy Studies in Family Medicine and Primary Care found that while the number of patients who seek care at community health centers has increased, the number of primary care providers, including physician assistants, has not. The report estimates a need for 15,500 primary health care providers to provide care at community health centers.

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

(1) The National Institute of Mental Health estimates that 26.2 percent of citizens of the United

States ages 18 and older suffer from a diagnosable mental disorder. Approximately 20 percent of children in the United States have diagnosable mental disorders with at least mild functional impairment.

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

(3) According to the Department of Health and Human Services, minority representation is lacking in the mental health workforce. Although 12 percent of the population of the United States is African-American, only 2 percent of psychologists, 2 percent of psychiatrists, and 4 percent of social workers are African-American. Moreover, there are only 29 mental health professionals who are Hispanic for every 100,000 individuals who are Hispanic in the United States, compared with 173 non-Hispanic White providers for every 100,000 individuals who are non-Hispanic White in the United States.

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

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

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

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

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

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

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

TITLE I—AMENDMENTS TO THE SOCIAL SECURITY ACT

SEC. 101. PERMANENT NATIONAL HEALTH WORKFORCE COMMISSION.

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

(b) DUTIES.—

(1) REVIEW OF FEDERAL POLICIES AND ANNUAL REPORTS.—

(A) REVIEW.—The Commission shall review Federal policies with respect to the training, financing, and distribution of the health professional workforce, particularly with respect to such workforce in rural, frontier, and urban underserved areas, including the specific topics described in paragraph (2). Such review shall include a comprehensive analysis and reporting of—

(i) the most recent COHPPERDDUST Annual Report;

(ii) the number of medical students and residents, physician assistant students, pharmacy students and residents, behavioral and mental health students and residents, dental students and residents, nursing students and advance practice nursing trainees, and other health professionals in need of training, the rates of payment for such training; and the methodologies for funding such training;

(iii) how to align payments for direct graduate medical education costs under section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) and payments for

the indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) with other Federal and State subsidies and payments for health professions education with desired outcomes for the health professional workforce;

(iv) whether Federal medical facilities should be permitted to train health professionals with support paid directly by the entity sponsoring the health professional;

(v) whether the establishment of transparent, accountable Federal payment policies for training health professionals would ensure that the types of health professionals trained and the distribution of such health professionals would meet the health care needs of the population of the United States;

(vi) the feasibility of establishing a National Health Professions Education Trust Fund to ensure an open and fair system of Federal, State, and private support for providing education for health professionals; and

(vii) any other issues related to such Federal policies as the Commission determines appropriate.

(B) COHPPERDDUST ANNUAL REPORTS.—Not later than each of January 1 of each year (beginning with 2012) the Commission shall submit to the Secretary and to Congress a report containing—

(i) the results of the review conducted under subparagraph (A); and

(ii) recommendations—

(I) with respect to the Health Professions Pipeline, Education, Research, Diversity & Distribution to Underserved Areas Utilizing Service/Training Models; and

(II) for such legislation or administrative action, including regulations, as the Commission determines appropriate.

(2) SPECIFIC TOPICS DESCRIBED.—

(A) PAYMENTS FOR HEALTH PROFESSIONS EDUCATION.—Specifically, the Commission shall review, with respect to the training, fi-

nancing, and distribution of the health professional workforce, the following:

(i) The regular update, revision, and standardization of hospital-specific and sponsoring institution-specific base-period per resident amounts and cost reporting periods for payments for direct graduate medical education costs under section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) and payments for the indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)).

(ii) The feasibility of the Secretary, subject to review by the Commission, granting a waiver under the Medicare program, such as the waiver granted to the Utah Medical Education Commission, which would allow States flexibility to utilize funding under titles XVIII, XIX, and XXI of the Social Security Act for direct graduate medical education and indirect graduate medical education to support coordinated and comprehensive health workforce training innovations.

(iii) Replacement of the current methodology for making payments for such direct graduate medical education costs and such indirect costs of medical education with a workforce adjustment payment, based on a Sustainable Growth Rate formula or a prospective payment system, under which—

(I) payments would be made directly to the sponsoring institution where such education is provided; and

(II) payments would be separated to reflect the costs to the professional and facility components of such education.

(iv) The establishment of standards for the financing of education for health professionals who are not physicians.

(v) The expansion of the definition, for purposes of making payments for health professions education (including such direct graduate medical education costs and such indirect costs of medical education), of the term ''sponsoring institution'', which traditionally has been a

teaching hospital or medical school, to include nonteaching hospital-based entities (such as managed care organizations and public and private healthcare consortia) that are capable of assembling all of the resources necessary for effectively providing the training and education required to address healthcare access, quality, and costs and to meet workforce needs.

(vi) The provision of health professions education by nonteaching hospital-based entities (including rural health clinics (as defined in subsection (aa)(2) of section 1861 of the Social Security Act (42 U.S.C. 1395x)), community health centers (as defined in section 330 of the Public Health Service Act (42 U.S.C. 254b)), and Federally qualified health centers (as defined in subsection (aa)(4) of such section 1861) that are not sponsoring institutions (as defined under clause (v)) as affiliates of the sponsoring institution for purposes of providing more limited, but highly valuable clinical training.

(vii) The establishment of incentives to promote interdisciplinary, team-based, and care coordination-based education of health professionals, including incentives to encourage the development of health information technology (such as a repository of consumer health status information in computer processable form) which can be used for diagnosis, management, and treatment and includes price and cost information.

(viii) Adjustment to the Medicare caps on graduate medical education positions to increase the number of primary care residents, general dentistry residents, geriatric fellowship trainees, and other health professionals trained in Federal medical facilities.

(ix) The development of pay-for-performance methodologies for payments for health professions education (including such direct graduate medical education costs, payments for such indirect costs of medical education, and disproportionate share payments under section

1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F))) to—

(I) increase payments to sponsoring institutions and the affiliates of such institutions that achieve desired outcomes; and

(II) reduce payments to such institutions and such affiliates that do not perform.

(x) The correlation between Federal policies with respect to the training, financing, and distribution of the health professional workforce and specific evidence-based, measurable, and comparative outcomes across sponsoring institutions and the affiliates of such institutions.

(xi) Disproportionate share payments under section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)) made to service and training institutions that provide safety net access, community-based outreach programs, measurable and transparent community benefit, and planned financial assistance to low-income patients, Medicare beneficiaries, and

underinsured (including uninsured) individuals in rural, frontier, and urban underserved areas.

(xii) The establishment of a workforce adjustment payment under the Medicare program under title XVIII of the Social Security Act, the Medicaid program under title XIX of such Act, the State Children's Health Insurance Program under title XXI of such Act, and other publicly funded health insurance programs to support training programs for health professionals in Federal medical facilities, under which such workforce adjustment payment would be made directly to the sponsoring institution. Such payment would, as the Secretary determines appropriate, in consultation with the Commission, replace or supplement the provisions under clause (iii).

(B) DATA COLLECTION AND REVIEW.—Specifically, the Commission shall review, with respect to the adequacy, supply, and distribution of undergraduate and graduate education programs for health professionals, the following:

(i) Available data on the adequacy, supply, and distribution of such education programs for physicians, physician assistants, nurses, dentists, psychologists, pharmacists, behavioral and mental health professionals (as defined in section 331(a)(3)(E)(i) of the Public Health Service Act (42 U.S.C. 254d(a)(3)(E)(i)), public health professionals, and other health professionals, including data collected under the State Health Workforce Centers Program established under section 102.

(ii) Processes for improving the collection of data on health professionals, including the collection of more consistent, independent, and comprehensive data from entities (such as State licensure boards) to inform health professions workforce issues. In conducting such review, the Commission shall determine the costs of implementing such data collection.

(3) CONDUCT OF HEARINGS.—

(A) IN GENERAL.—The Commission shall conduct hearings on health professions education to assess performance, identify barriers,

speed approval of innovative programs, improve flexibility, and reduce bureaucratic obstacles balancing hospital training while emphasizing sustained affiliation agreements with community-based, interdisciplinary, team, and care management methodologies and education designed to improve quality and efficiency of patient care across the care delivery system.

(B) TESTIMONY.—In conducting hearings under subparagraph (A), the Commission shall solicit testimony from the Accreditation Council for Graduate Medical Education, Residency Review Committees, and other appropriate organizations that accredit education programs for health professionals.

(C) INFORMATION FROM FEDERAL AGENCIES.—

(i) IN GENERAL.—The Commission may secure directly from a Federal agency such information as the Commission considers necessary to carry out this section.

(ii) PROVISION OF INFORMATION.—The head of the agency shall provide the information to the Commission at the re-

quest of the Chairperson of the Commission.

(4) REDUCING HEALTH PROFESSIONAL ISOLATION AND BUILDING COMMUNITY HEALTH PROFESSIONAL TRAINING INFRASTRUCTURE.—

(A) IDENTIFICATION OF PROGRAMS.—The Commission shall identify programs to reduce health professional isolation and build community health professional training infrastructure in rural, frontier, and urban underserved areas through continuing education (including continuing education utilizing information technology, such as telehealth and health information technology), mentoring, and precepting activities.

(B) ANALYSIS.—The Commission shall examine—

(i) whether the establishment of regional or statewide Health Advice Lines would reduce after-hours calls responsibilities for overworked health professionals in remote sites with few health professionals available to fulfill such responsibilities;

(ii) what support should be given to health professionals fulfilling such responsibilities—

(I) in hospitals and emergency departments in areas designated under section 332 of the Public Health Service Act as health professional shortage areas;

(II) under practice relief programs that allow health professionals practicing in such areas to have their practice and calls covered when they are ill, pursuing continuing education, or taking a vacation; and

(III) with respect to field faculty development to become supervisors, mentors, and preceptors for health professional students and trainees;

(iii) support structures (such as Area Health Education Centers) for health professionals; and

(iv) whether the establishment of Rural Health Education Offices, based on the model of agricultural extension offices, would—

(I) help build community health professional service and training capacity; and

(II) spur local economic development.

(5) DEVELOPMENT OF GUIDING PRINCIPLES AND ACCOUNTABILITY STANDARDS.—The Commission shall develop guiding principles and accountability standards for Federal, State, and private sector education of health professionals. Such guidelines shall be crafted to assure that the Federal investment in the education of health professionals is a public good, regardless of whether a portion of such education is funded by other sources.

(6) IDENTIFICATION OF STATE AND REGIONAL HEALTH PROFESSIONS EDUCATION COMMISSIONS.—The Commission shall identify State and regional Health Professions Education Centers. The Commission shall enter into agreements with such Centers under which the Centers shall provide data and reports to the Commission to provide a balanced and adequate assessment of the entire Nation's healthcare workforce.

(c) SECRETARIAL RESPONSIBILITIES.—Not later than 18 months after the date of enactment of this Act,

the Secretary shall, in consultation with the Commission, and through negotiated rulemaking, promulgate regulations to address the matters reviewed under clauses (i) through (vii) of subsection (b)(1)(A), as the Secretary determines appropriate to address access and health professional shortages and needs identified by the Commission with respect to titles XVIII, XIX, and XXI of the Social Security Act.

(d) MEMBERSHIP.—

(1) NUMBER OF APPOINTMENT.—The Commission shall be composed of 20 members appointed by the Comptroller General of the United States.

(2) QUALIFICATIONS.—The membership of the Commission shall include representatives of—

(A) dentists and dental hygienists who practice in urban underserved and rural areas;

(B) primary care providers who practice in urban underserved and rural areas;

(C) nurses and physician assistants who practice in urban underserved and rural areas;

(D) psychologists and other behavioral and mental health professionals (as defined in section 331(a)(3)(E)(i) of the Public Health Service Act (42 U.S.C. 254d(a)(3)(E)(i)) who practice in urban underserved and rural areas;

(E) public health professionals;

(F) clinical pharmacists who practice in a Federal market or are sole-community providers;

(G) national and specialty physician and nursing organizations;

(H) schools of medicine, osteopathy, and nursing, educational programs for public health professionals, behavioral and mental health professionals (as so defined), and physician assistants, public and private teaching hospitals, and ambulatory health facilities, including Federal medical facilities;

(I) health insurers;

(J) business;

(K) labor; and

(L) any other health professional organization or practice site the Comptroller General determines appropriate.

(e) STAFF.—

(1) IN GENERAL.—The Comptroller General of the United States shall provide for the appointment of an executive director, deputy director, and such other additional personnel as are necessary to enable

the Commission to perform the duties of the Commission.

(2) COMPENSATION.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the Comptroller General of the United States may fix the compensation of the executive director, deputy director, and other personnel without regard to the provisions of chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates.

(B) MAXIMUM RATE OF PAY.—The rate of pay for the executive director, deputy director, and other personnel shall not exceed the rate payable for level V of the Executive Schedule under section 5316 of title 5, United States Code.

(3) DETAIL OF FEDERAL GOVERNMENT EMPLOYEES.—

(A) IN GENERAL.—An employee of the Federal Government may be detailed to the Commission without reimbursement.

(B) CIVIL SERVICE STATUS.—The detail of the employee shall be without interruption or loss of civil service status or privilege.

(4) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES.—The Commission may procure temporary and intermittent services in accordance with section 3109(b) of title 5, United States Code, at rates for individuals that do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of that title.

(f) POWERS.—

(1) HEARINGS.—The Commission may hold such hearings, meet and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out this section.

(2) INFORMATION FROM FEDERAL AGENCIES.—

(A) IN GENERAL.—The Commission may secure directly from a Federal agency such information as the Commission considers necessary to carry out this section.

(B) PROVISION OF INFORMATION.—On request of the Chairperson of the Commission,

the head of the agency shall provide the information to the Commission.

(3) POSTAL SERVICES.—The Commission may use the United States mails in the same manner and under the same conditions as other agencies of the Federal Government.

(4) GIFTS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

(g) STATUS AS PERMANENT COMMISSION.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Commission.

(h) DEFINITIONS.—In this section:

(1) COHPPERDDUST ANNUAL REPORT.—The term ''COHPPERDDUST Annual Report'' means the annual report submitted by the Commission under subsection (b)(1)(B).

(2) FEDERAL MEDICAL FACILITY.—The term ''Federal medical facility'' means a facility for the delivery of health services, and includes—

(A) a Federally qualified health center (as defined in section 1861(aa)(4) of the Social Security Act (42 U.S.C. 1395x(aa)(4)), a public health center, an outpatient medical facility, or a community mental health center;

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

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

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

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

(F) a nurse-managed health center; or

(G) any other Federal medical facility.

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

SEC. 102. STATE HEALTH WORKFORCE CENTERS PROGRAM.

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

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

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

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

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

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

(d) FUNDING.—

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

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

(e) DEFINITIONS.—In this section:

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

(2) STATE.—The term ''State'' means—

(A) a State;

(B) the District of Columbia;

(C) the Commonwealth of Puerto Rico; and

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

SEC. 103. MEDICARE MEDICAL HOME SERVICE AND TRAINING PILOT PROGRAM.

(a) EXPANSION OF MEDICARE MEDICAL HOME DEMONSTRATION PROJECT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall expand the Medicare medical home demonstration project under section 204 of Division B of the Tax Relief and Health Care Act of 2006 (Public Law 109–432; 120 Stat. 2987) by adding a Medicare medical home service and training pilot program (in this section referred to as the ''pilot program'') to redesign the methodologies for payments to primary care providers for coordinating the care of applicable Medicare beneficiaries. Such pilot program shall be in addition to, and run concurrently with, the Medicare medical home demonstration program. Except for any modifications under this section, the Secretary shall carry out the pilot program under similar terms and conditions as the Medicare medical home demonstration program.

(2) APPLICABLE MEDICARE BENEFICIARIES DEFINED.—In this section, the term ''applicable Medicare beneficiary'' means an individual who—

(A) is entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act, or is enrolled under part B of such title;

(B) has 1 or more chronic illnesses (such as diabetes, hypertension, chronic obstructive pulmonary disease, asthma, congestive heart failure, end stage liver disease, and end stage renal disease); and

(C) is in the top 2 quartiles of cost under the Medicare program under such title (as determined based on Medicare claims data for the most recent 2 years for which data is available).

(b) DETAILS.—

(1) DURATION; SCOPE.—The pilot program shall operate during the period beginning on January 1, 2011, and ending on December 31, 2014, and shall include not more than 1,000 medical home primary care providers.

(2) IMPLEMENTATION.—

(A) IN GENERAL.—The Secretary may implement the pilot program—

(i) under title XVIII of the Social Security Act; or

(ii) subject to subparagraph (B), under a combination of such title and other public or private programs or organizations.

(B) SPECIAL RULE.—In the case where the Secretary implements the pilot program under a combination of title XVIII of the Social Security Act and other public or private programs or organizations, the Secretary shall establish procedures to ensure that any funding made available under such title for the pilot program is only used to furnish items and services to Medicare beneficiaries.

(3) PARTICIPATION OF PRIMARY CARE PROVIDERS.—

(A) IN GENERAL.—In no case shall participation in the pilot program be limited to primary care providers in those States participating in the Medicare medical home demonstration project under section 204 of Division B of the Tax Relief and Health Care Act of 2006 (Public Law 109–432; 120 Stat. 2987). Any primary care provider in the United States

that meets the requirements and definitions under this section and, if applicable, such section 204, shall be eligible to participate in the pilot program. In selecting primary care providers to participate in the pilot program, the Secretary shall give preference to sites where clinical services and health professional education are provided concurrently, taking into consideration priorities of the Permanent National Health Workforce Commission established under section 101 of the Health Access and Health Professions Supply Act of 2009.

(B) DEFINITION OF PRIMARY CARE PROVIDERS.—In this section, the term ''primary care provider'' means—

(i) a personal physician (as defined in subsection (c)(1) of section 204 of Division B of the Tax Relief and Health Care Act of 2006 (Public Law 109–432; 120 Stat. 2987), except that, in applying such definition under this section, the requirements described in subsection (c)(2)(B) of such section 204 shall specify that the staff and resources of the physician may include a team of health professionals (such as nurse

practitioners, clinical nurse specialists, certified nurse midwives, psychologists and other behavioral and mental health professionals (as defined in section 331(a)(3)(E)(i) of the Public Health Service Act (42 U.S.C. 254d(a)(3)(E)(i)), physician assistants, and other primary care providers that meet requirements established by the Secretary)); and

(ii) any other primary care provider (such as a nurse practitioner or a physician assistant) that is subject to State licensure laws and the requirements of the Secretary.

(C) LIMITATION ON NUMBER OF PRIMARY CARE PROVIDERS PARTICIPATING IN THE PILOT PROGRAM WHO ARE NOT PERSONAL PHYSICIANS.—The Secretary shall ensure that the total number of independently practicing primary care providers who are not personal physicians participating in the pilot program reflects the percentage of such primary care providers in the United States (as determined by the Secretary), not to exceed 10 percent of the total

number of primary care providers participating in the pilot program.

(4) SERVICES PERFORMED.—A primary care provider shall perform or provide for the performance of at least the services described in subsection (c)(3) of such section 204 under the pilot program.

(c) CARE COORDINATION FEE PAYMENT METHODOLOGY.—Under the pilot program, the Secretary shall provide for payment under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) of a per member per month care coordination fee to primary care providers for the care of eligible Medicare beneficiaries participating in the pilot program. The Secretary shall appoint a committee to make recommendations about the design and implementation of a methodology for payment of the per member per month care coordination fee.

(d) PROVISION OF DATA AND TECHNICAL ASSISTANCE.—The Secretary shall provide—

(1) data to primary care providers participating in the pilot program; and

(2) technical assistance to such primary care providers that do not meet the criteria for the highest tier of the pilot program (as defined by the Secretary).

(e) REPORTS BY THE SECRETARY.—

(1) INTERIM REPORT.—Not later than January 1, 2013, the Secretary shall submit to Congress an interim report on the pilot program.

(2) FINAL REPORT.—Not later than January 1, 2014, the Secretary shall submit to Congress a final report on the pilot program. Such report shall include outcome measures reported by the Secretary under the pilot program, including at least the following:

(A) The total costs to the Medicare program per eligible Medicare beneficiary participating in the pilot program.

(B) The performance of primary care providers participating in the pilot program with regard to—

(i) quality measures developed by the Secretary; and

(ii) patient safety indicators developed by the Secretary.

(C) The experience of eligible Medicare beneficiaries and primary care providers participating in the pilot program.

(D) An assessment of savings to the Medicare program per eligible Medicare beneficiary participating in the pilot program that are a re-

sult of such participation, as compared to traditional Medicare fee-for-service payment methodologies.

(f) GAO ASSESSMENT AND REPORT.—

(1) ASSESSMENT.—The Comptroller General of the United States shall, at the completion of the pilot program, provide for an overall assessment of the efficacy of the pilot program.

(2) REPORT.—Not later than January 1, 2014, the Comptroller General shall submit to Congress a report containing the results of the assessment under paragraph (1).

SEC. 104. IMPROVEMENTS TO PAYMENTS FOR GRADUATE MEDICAL EDUCATION UNDER MEDICARE.

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

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

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

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

''(iii) INCREASE IN CAPS ON GRADUATE MEDICAL EDUCATION POSITIONS FOR

STATES WITH A SHORTAGE OF RESIDENTS.—

"(I) IN GENERAL.—For cost reporting periods beginning on or after January 1, 2011, the Secretary shall increase the otherwise applicable limit on the total number of full-time equivalent residents in the field of allopathic or osteopathic medicine determined under clause (i) with respect to a qualifying hospital by an amount equal to 15 percent of the amount of the otherwise applicable limit (determined without regard to this clause). Such increase shall be phased-in equally over a period of 3 cost reporting periods beginning with the first cost reporting period in which the increase is applied under the previous sentence to the hospital.

"(II) QUALIFYING HOSPITAL.—In this clause, the term 'qualifying hospital' means a hospital that agrees to use the increase in the number of full-time equivalent residents under

subclause (I) to support community-based training which emphasizes underserved areas and innovative training models which address community needs and reflect emerging, evolving, and contemporary models of health care delivery. A qualifying hospital shall give priority to providing such training and training models to health professionals in specialties which the Secretary, in consultation with the Permanent National Health Workforce Commission established under section 101(a) of the Health Access and Health Professions Supply Act of 2009, determines are in high-need (including family medicine, general surgery, geriatrics, general internal medicine, general surgery, and obstetrics and gynecology).

''(III) INCREASE IN PAYMENTS.—Notwithstanding any other provision of law, in the case of full-time equivalent residents added to a hospital's training program as a result

of such increase, the Secretary shall provide for an increase in the amounts otherwise payable under this subsection with respect to direct graduate medical education costs that would otherwise apply with respect to such residents by 10 percent. Such increased payments shall be made to the facility in which the training is provided to such residents.''.

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

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

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

(1) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall, by regulation, provide for the use of payments for direct graduate medical education costs under section 1886(h) of the Social Se-

curity Act (42 U.S.C. 1395ww(h)) and payments for the indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) to support the implementation of community-based training and innovative training models under subsections (h)(4)(F)(iii)(II) and (d)(5)(B)(x) of section 1886 of the Social Security Act (42 U.S.C. 1395ww).

(2) USE OF MODEL OF CARE DELIVERY.—In promulgating regulations under paragraph (1), the Secretary shall consider the model of care delivery of the Institute of Medicine of the National Academies.

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

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

"(G) FLEXIBILITY IN DETERMINATION.—

"(i) IN GENERAL.—Notwithstanding the preceding provisions of this paragraph, the approved FTE resident amount for

each cost reporting period beginning on or after January 1, 2011, with respect to an applicable resident shall be determined using a methodology established by the Secretary that allows flexibility for payments to be made for costs in addition to the costs of hospital-sponsored education. Such methodology shall provide that non-teaching hospital-based entities (such as managed care organizations and public and private healthcare consortia) that are capable of assembling all of the resources necessary for effectively providing graduate medical education may receive payments for providing graduate medical education, either as the sponsor of such graduate medical education program or as an affiliate of such a sponsor.

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

''(I) in a specialty which the Secretary, in consultation with the Permanent National Health Workforce Commission established under section

101(a) of the Health Access and Health Professions Supply Act of 2009, determines is in high-need;

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

"(III) in a medically underserved community (as defined in section 799B of the Public Health Service Act), or with respect to a medically underserved population (as defined in section 330(b)(3) of the Public Health Service Act); and

"(IV) in a Federal medical facility.

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

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

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

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

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

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

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

SEC. 105. DISTRIBUTION OF RESIDENT TRAINEES IN AN EMERGENCY.

(a) EXCLUSION FROM 3-YEAR ROLLING AVERAGE.—Notwithstanding any other provision of law, in the case of a host hospital participating in an emergency Medicare GME affiliation agreement on or after the date of enactment of this Act and training residents in excess of its cap, consistent with the rolling average provisions applica-

ble for closed programs as specified in section 413.79(d)(6) of title 42, Code of Federal Regulations, the Secretary of Health and Human Services shall exclude from the 3-year rolling average FTE residents associated with displaced residents during the period in which such agreement is in effect.

(b) ASSESSMENT AND REVISION OF GME POLICIES.—

(1) REVIEW.—The Secretary of Health and Human Services shall review policies with respect to payments for direct graduate medical education costs under section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) and payments for the indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)).

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

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

(B) in the case where the Secretary determines legislative action is necessary to make such revisions, submit to Congress a report con-

taining recommendations for such legislative action.

SEC. 106. AUTHORITY TO INCLUDE COSTS OF TRAINING OF PSYCHOLOGISTS IN PAYMENTS TO HOSPITALS FOR APPROVED EDUCATIONAL ACTIVITIES UNDER MEDICARE.

Effective for cost reporting periods beginning on or after the date that is 18 months after the date of enactment of this Act, for purposes of payment to hospitals under the Medicare program under title XVIII of the Social Security Act for costs of approved educational activities (as defined in section 413.85 of title 42, Code of Federal Regulations), such approved educational activities shall include a 1-year doctoral clinical internship operated by the hospital as part of a clinical psychology training program that is provided upon completion of university course work.

TITLE II—AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT

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

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

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

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

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

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

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

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

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

(2) by adding at the end the following:

''(d) EXPANSION OF PROGRAMS.—The Secretary shall use amounts appropriated for each of fiscal years 2010 through 2014 under subsection (a), that are in excess of the amount appropriated under such subsection for fiscal year 2009, to address shortages of health professionals in rural, frontier, and urban underserved areas through an expansion of the number of scholarships and loan repayments under this subpart to address health workforce shortages in health professional shortage areas (as defined in section 332), in medically underserved communities (as defined in section 799B), or with respect to medically underserved populations (as defined in section 330(b)(3)).''.

(b) EXPANSION OF OTHER PROGRAMS.—The Director of the Indian Health Service, the Secretary of Defense, and the Secretary of Veterans Affairs, shall expand existing loan repayment programs to emphasize the provision

of health professions services to facilities that have health professional shortages.

(c) NO TAX IMPLICATIONS.—

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

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

(A) a federally qualified health center (as defined in section 330A of the Public Health Service Act (42 U.S.C. 254c)), a public health center, an outpatient medical facility, or a community mental health center;

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

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

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

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

(F) a nurse-managed health center; or

(G) any other Federal medical facility.

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

''(e) Notwithstanding any other provision of this subpart, the Secretary shall develop procedures to permit periods of obligated services to be provided on a part-time basis (not less than 1,040 hours of such service per year). Such procedures shall prohibit an individual from holding other part-time employment while providing such part-time obligated services. The Secretary may provide for a reduction in the loan repayments provided to individuals who provide part-time obligated services under the authority provided under this subsection.''.

(e) LOAN SUPPORT FOR PARTICIPATING PRECEPTORS, MENTORS, AND ATTENDINGS TO SUPERVISE STUDENTS AND TRAINEES ON-SITE.—Section 338C of the Public Health Service Act (42 U.S.C. 254m), as amended

by subsection (d), is further amended by adding at the end the following:

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

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

(a) PROGRAM AUTHORIZED.—

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

(A) in the heading by inserting ''**, Scholarship Program for Medical, Dental, Physician Assistant, Pharmacy, Behavioral and Mental Health, Public**

Health, and Nursing Students in the United States Public Health Sciences Track in Affiliated Schools,'' after ''**Scholarship Program**''; and

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

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

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary shall establish a program to be known as the National Health Service Corps Scholarship Program for Medical, Dental, Physician Assistant, Pharmacy, Behavioral and Mental Health, Public Health, and Nursing Students in the United States Public Health Sciences Track in Affiliated Schools (in this section referred to as the 'U.S. Public Health Sciences Track Scholarship Program) to ensure, with respect to the provision of high-needs health care services, including primary care, general dentistry, nursing, obstetrics,

and geriatricians pursuant to section 331(a)(2), an adequate supply of physicians, physician assistants, pharmacists, behavioral and mental health professionals, public health professionals, dentists, and nurses. The purpose of this program is to train an additional 150 medical students, 100 dental students, 100 physician assistant students, 100 behavioral and mental health students, 100 public health students, and 250 nursing students during each year. Of the 150 scholarships awarded to the medical students as described under the preceding sentence, 10 shall be for training at the Uniformed Services University of the Health Sciences as members of the Commissioned Corps of the Public Health Service.

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

program under the National Health Service Corps Scholarship Program authorized by section 338A.

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

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

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

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

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

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

''(4) sign and submit to the Secretary, at the time of submittal of such application, a written contract to accept payment of a scholarship and to

serve (in accordance with this subpart) for the applicable period of obligated service in an area in which the need for public health-related services may be demonstrated.''.

(2) NO TAX IMPLICATIONS.—For purposes of the Internal Revenue Code of 1986, any amount received under the National Health Service Corps Scholarship Program for Medical, Dental and Nursing Students in the United States Public Health Sciences Track in Affiliated Schools under section 338A–1 of the Public Health Service Act, as added by paragraph (1), by a medical student, dental student, or nursing student shall not be included in the gross income of such student.

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

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

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

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

''(2) To develop curriculum.

''(3) To acquire equipment.

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

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

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

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

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

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

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

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

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

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

"SEC. 781. FEDERAL MEDICAL FACILITY GRANT PROGRAM.

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

''(b) ELIGIBLE FACILITIES; APPLICATION.—

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

''(A) means a facility which—

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

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

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

''(iii) is a Federal medical facility;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

outpatient medical facility, or a community mental health center;

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

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

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

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

''(6) any other Federal medical facility.

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

(b) ASSESSMENTS.—

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

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

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

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

SEC. 204. HEALTH PROFESSIONS TRAINING LOAN PROGRAM.

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

"SEC. 782. ESTABLISHMENT.

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

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

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

''(b) ELIGIBILITY.—

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

''(A) a hospital shall—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(e) LOAN PROVISIONS.—

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

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

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

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

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

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

SEC. 205. UNITED STATES PUBLIC HEALTH SCIENCES TRACK.

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

"PART D—UNITED STATES PUBLIC HEALTH SCIENCES TRACK

"SEC. 271. ESTABLISHMENT.

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

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

''(A) 150 medical students annually;

''(B) 100 dental students annually;

''(C) 250 nursing students annually;

''(D) 100 public health students annually;

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

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

''(G) 50 pharmacy students annually.

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

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

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

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

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

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

"SEC. 272. ADMINISTRATION.

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

''(b) FACULTY.—

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

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

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

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

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

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

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

''(2) A graduate school of nursing.

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

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

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

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

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

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

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

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

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

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

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

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

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

''(a) STUDENT SELECTION.—

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

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

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

''(b) CONTRACT AND SERVICE OBLIGATION.—

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

''(A) an agreement under which—

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

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

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

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

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

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

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

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

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

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

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

''(2) TUITION AND STUDENT STIPEND.—

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

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

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

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

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

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

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

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

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

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

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

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

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

''SEC. 274. AUTHORIZATION OF APPROPRIATIONS.

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

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

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

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

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

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

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

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

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

TITLE III—HEALTH PROFESSIONAL TRAINING PIPELINE PARTNERSHIPS PROGRAM

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

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

(b) DEFINITIONS.—In this section:

(1) CHILDREN FROM LOW-INCOME FAMILIES.—The term ''children from low-income families'' means children described in section 1124(c)(1)(A) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6333(c)(1)(A)).

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

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

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

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

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

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

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

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

(C) that meets the eligibility requirements for funding under the Small, Rural School Achievement Program under section 6211(b) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7345(b)); or

(D) that meets the eligibility requirements for funding under the Rural and Low-Income School Program under section 6221(b)(1) of

the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7351(b)(1)).

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

(A) the local educational agencies;

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

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

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

(c) GRANTS AUTHORIZED.—

(1) IN GENERAL.—The Secretary is authorized to award grants, on a competitive basis, to eligible recipients to enable the recipients to develop and implement programs of study to prepare middle school

and high school students for postsecondary education leading to careers in the healthcare field.

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

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

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

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

(1) applicants that include a local educational agency that is located in an area that is designated under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)) as a health professional shortage area;

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

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

(f) AUTHORIZED ACTIVITIES/USE OF FUNDS.—

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

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

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

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

(ii) necessary to enter healthcare jobs directly.

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

(A) involve a review and identification of the content knowledge and skills students who enter institutions of higher education and the

workforce need to have in order to succeed in the healthcare field;

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

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

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

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

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

(G) consider the inclusion of a distance-learning component or similar education tech-

nology that would expand opportunities for geographically isolated individuals;

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

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

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

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

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

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

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

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

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

(h) REPORTS.—

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

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

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

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

(D) the number of program participants who reported enrollment in some form of post-

secondary education with the potential to lead to a career in the healthcare field;

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

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

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

(i) AUTHORIZATION AND APPROPRIATION.—

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

(2) ADMINISTRATIVE COSTS.—For the costs of administering this section, including the costs of evaluating the results of grants and submitting reports to the Congress, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2009 through 2013.

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