of S. 1067, a bill to support stabilization and lasting peace in northern Uganda and areas affected by the Lord's Resistance Army through development of a regional strategy to support multilateral efforts to successfully protect civilians and eliminate the threat posed by the Lord's Resistance Army and to authorize funds for humanitarian relief and reconstruction, reconciliation, and transitional justice, and for other purposes.

S. 1076

At the request of Mr. MENENDEZ, the name of the Senator from Pennsylvania (Mr. CASEY) was added as a cosponsor of S. 1076, a bill to improve the accuracy of fur product labeling, and for other purposes.

S. 1103

At the request of Mr. VITTER, the name of the Senator from Arizona (Mr. KYL) was added as a cosponsor of S. 1103, a bill to amend the Help America Vote Act of 2002 to establish standards for the distribution of voter registration application forms and to require organizations to register with the State prior to the distribution of such forms.

S. 1113

At the request of Mr. PRYOR, the name of the Senator from Louisiana (Mr. VITTER) was added as a cosponsor of S. 1113, a bill to amend title 49, United States Code, to direct the Secretary of Transportation to establish and maintain a national clearinghouse for records related to alcohol and controlled substances testing of commercial motor vehicle operators, and for other purposes.

S. 1121

At the request of Mr. HARKIN, the name of the Senator from Massachusetts (Mr. KENNEDY) was added as a cosponsor of S. 1121, a bill to amend part D of title V of the Elementary and Secondary Education Act of 1965 to provide grants for the repair, renovation, and construction of elementary and secondary schools, including early learning facilities at the elementary schools.

S. 1147

At the request of Mr. KOHL, the names of the Senator from New York (Mrs. GILLIBRAND) and the Senator from New York (Mr. SCHUMER) were added as cosponsors of S. 1147, a bill to prevent tobacco smuggling, to ensure the collection of all tobacco taxes, and for other purposes.

S. 1148

At the request of Mr. GRASSLEY, the names of the Senator from Kansas (Mr. BROWNBACK) and the Senator from Nebraska (Mr. JOHANNS) were added as cosponsors of S. 1148, a bill to amend the Clean Air Act to modify a provision relating to the renewable fuel program.

S. CON. RES. 14

At the request of Mr. BARRASSO, the name of the Senator from Kansas (Mr. ROBERTS) was added as a cosponsor of S. Con. Res. 14, a concurrent resolution supporting the Local Radio Freedom Act.

S. RES. 71

At the request of Mr. WYDEN, the name of the Senator from Maryland (Mr. CARDIN) was added as a cosponsor of S. Res. 71, a resolution condemning the Government of Iran for its state-sponsored persecution of the Baha'i minority in Iran and its continued violation of the International Covenants on Human Rights.

S. RES. 142

At the request of Mr. ENZI, the names of the Senator from Nebraska (Mr. JOHANNS), the Senator from Kansas (Mr. ROBERTS) and the Senator from Idaho (Mr. RISCH) were added as cosponsors of S. Res. 142, a resolution designating July 25, 2009, as ''National Day of the American Cowboy''.

AMENDMENT NO. 1229

At the request of Mr. VITTER, his name was added as a cosponsor of amendment No. 1229 intended to be proposed to H.R. 1256, to protect the public health by providing the Food and Drug Administration with certain authority to regulate tobacco products, to amend title 5, United States Code, to make certain modifications in the Thrift Savings Plan, the Civil Service Retirement System, and the Federal Employees' Retirement System, and for other purposes.

At the request of Mr. DORGAN, the names of the Senator from Iowa (Mr. GRASSLEY) and the Senator from Wisconsin (Mr. FEINGOLD) were added as cosponsors of amendment No. 1229 intended to be proposed to H.R. 1256, supra.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. REID:

S. 1166. A bill to amend the Internal Revenue Code of 1986 to allow taxpayers to designate part or all of any income tax refund to support reservists and National Guard members; to the Committee on Finance.

Mr. REID. Mr President, I rise today to introduce legislation to help reduce the financial burden placed on our Reserve and National Guard troops and their families. More than a quarter of a million have deployed in support of operations in Iraq and Afghanistan, and we must make it a priority to honor their service at home.

Nevada alone has more than three thousand Guards men and women, and a thousand Reservists—many of whom work full-time jobs when they are not on active duty. Since September 11th, our National Guard and Reserve Troops have significantly increased their deployments beyond what had been forecasted, advertised or expected. They have continued their engagements around the globe while still responding to historic callouts in support of disaster relief.

In our Democracy, we enjoy the luxury of an all-volunteer military force. Yet in volunteering, many of our Citizen-Soldiers are financially penalized for their service. Far too frequently, when a Service Member is mobilized in service to their state or our nation, they suffer a financial burden in the reduced pay received while mobilized. A National Guard medic might earn much less while he or she is deployed in Afghanistan than they did working a full-time job in a Nevada hospital. This legislation gives American taxpayers the option of contributing money to help our military families to make up for wages lost during a deployment.

The bill I am introducing today allows Americans to designate all or a portion of their income tax refunds to the Reserve Income Replacement Program. The Program is a compensation that must be paid to all eligible Service Members when they incur a loss in monthly income as a result of a mobilization. The funds that volunteers donate will be transferred from the Treasury Department to this program, which was developed specifically to provide payments to eligible members of the National Guard and Reserve who are involuntary serving on active-duty and who are experiencing a monthly active-duty income differential of more than $50. In 2007, the IRS issued 106 million refunds that totaled $246 billion with the average refund coming in at $2,342. Even a small percentage of this amount could make a significant difference in the lives of these reservist and National Guard families.

The financial stress of deployments during a recession has placed enormous pressures on our National Guard and Reserve Service Members and their families. Many of these members are returning from war only to find their businesses facing extreme difficulty. This bill would not only assist the Guard with monetary resources, but it would also rightfully focus more attention on the financial struggles that our brave and dedicated citizen Soldiers and Airmen undertake in defense of our country. With this legislation, we can show them that their service is not taken for granted.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 1166

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Voluntary Support for Reservists and National Guard Members Act''.

SEC. 2. DESIGNATION OF OVERPAYMENTS TO SUPPORT RESERVISTS AND NATIONAL GUARD MEMBERS.

(a) DESIGNATION.—Subchapter A of chapter 61 of the Internal Revenue Code of 1986 is amended by adding at the end the following new part:

''PART IX—DESIGNATION OF OVERPAYMENTS TO RESERVE INCOME REPLACEMENT PROGRAM

''Sec. 6097. Designation.

"SEC. 6097. DESIGNATION.

''(a) IN GENERAL.—In the case of an individual, with respect to each taxpayer's return for the taxable year of the tax imposed by chapter 1, such taxpayer may designate that a specified portion (not less than $5) of any overpayment of tax for such taxable year be paid over to the Reserve Income Replacement Program (RIRP) under section 910 of title 37, United States Code.

''(b) MANNER AND TIME OF DESIGNATION.—A designation under subsection (a) may be made with respect to any taxable year only at the time of filing the return of the tax imposed by chapter 1 for such taxable year. Such designation shall be made in such manner as the Secretary prescribes by regulations except that such designation shall be made either on the first page of the return or on the page bearing the taxpayer's signature.

''(c) OVERPAYMENTS TREATED AS REFUNDED.—For purposes of this title, any portion of an overpayment of tax designated under subsection (a) shall be treated as—

''(1) being refunded to the taxpayer as of the last date prescribed for filing the return of tax imposed by chapter 1 (determined without regard to extensions) or, if later, the date the return is filed, and

''(2) a contribution made by such taxpayer on such date to the United States.''.

(b) TRANSFERS TO RESERVE INCOME REPLACEMENT PROGRAM.—The Secretary of the Treasury shall, from time to time, transfer to the Reserve Income Replacement Program (RIRP) under section 910 of title 37, United States Code, the amounts designated under section 6097 of the Internal Revenue Code of 1986, under regulations jointly prescribed by the Secretary of the Treasury and the Secretary of Defense.

(c) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 61 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''PART IX. DESIGNATION OF OVERPAYMENTS TO RESERVE INCOME REPLACEMENT PROGRAM''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2009.

By Mr. PRYOR (for himself, Mr. BROWNBACK, Mr. BAYH, Mr. ISAKSON, Mr. CHAMBLISS, Mr. LUGAR, and Mr. INHOFE):

S. 1171. A bill to amend title XVIII of the Social Security Act to restore State authority to waive the 35–mile rule for designating critical access hospitals under the Medicare Program; to the Committee on Finance.

Mr. PRYOR. Mr. President, I rise today to introduce legislation with Senators BROWNBACK, BAYH, ISAKSON, and CHAMBLISS. The Critical Access Flexibility Act of 2009 will return to States the flexibility needed to help preserve local hospitals that serve rural communities.

Hospitals are often the largest employers in rural America. They provide much needed jobs and are facing serious financial difficulties during this economic downturn. Without immediate relief, many small hospitals are at serious risk of closure, job loss, or reductions in patient services. Rural areas most often have sicker, older, and poorer populations. In these difficult times, it is crucial that we protect hospitals serving our rural communities.

A Critical Access Hospital, CAH, is a hospital that is certified to receive cost-based reimbursement from Medicare. The reimbursement that CAHs receive is intended to improve their financial performance and thereby reduce hospital closures. CAHs are certified under a different set of Medicare conditions of participation that are more flexible than those used for acute care hospitals. In order for a hospital to be classified as a CAH, it must meet a number of conditions including a distance requirement that it must be 35 miles away from the nearest hospital. Prior to enactment of the 2003 Medicare Modernization Act, MMA, hospitals that were designated as ''necessary providers'' by a State could be exempt from the distance requirement.

I am joining with Senators BROWNBACK, BAYH, and ISAKSON today to introduce legislation that restores a state's authority to waive the mileage requirements if all other requirements are met and the State designates the facility as a necessary provider. Existing requirements that cannot be waived include requiring that CAHs be nonprofit or public hospitals in a rural area, offer 24-hour emergency room services, and have no more than 25 acute care inpatient beds.

There are at least two communities in my State where changing conditions are threatening small town hospitals, and restoring the flexibility for States to make exemptions for the distance requirement would help residents of these communities continue to be able to receive necessary medical care from a local hospital. I know from talking to my colleagues in the Senate and to health care providers that this is the case throughout rural America. In recent years, there have been legislative efforts for single hospitals to be singled out and granted an exemption to the distance requirement. I believe the best way to address this problem is to have a uniform national policy that gives States the flexibility they need.

I want to thank Senators BROWNBACK, BAYH, ISAKSON, and CHAMBLISS for their work, leadership and support on this very important legislation, and I urge the rest of my colleagues to support this effort.

By Mr. FEINGOLD:

S. 1173. A bill to establish a demonstration project to train unemployed workers for employment as health care professionals, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mr. FEINGOLD. Mr. President, today I introduce the Community-Based Health Care Retraining Act, which would amend the Workforce Investment Act to help communities with both significant job losses and shortages in the health care professions create programs to retrain displaced workers for high-demand health care jobs. I have introduced similar legislation in the past to help workers who are displaced from the manufacturing and service sectors.

In light of the state of our economy and the tremendous increase in unemployment across this country, I have tried to broaden the bill to cover workers from all sectors. According to the Department of Labor, in the last year the number of unemployed people in the United States has increased by 6 million. In April alone, private sector employment fell by 539,000, bringing the unemployment rate to 8.9 percent. In my home State of Wisconsin, the unemployment rate is up to 8.8 percent.

In Wisconsin, we have seen the loss of many manufacturing jobs, including at the idled General Motors automobile assembly plant in my hometown of Janesville, and in Kenosha, where Chrysler recently announced that the Kenosha Chrysler plant will cease production in 2010. But these large factories are just the tip of the iceberg. Some small manufacturing businesses are also going out of business in communities around Wisconsin, and others are struggling to survive.

In addition, the economic troubles in the last few years have permeated other industries besides manufacturing, including construction, business, and also the retail industry.

The people in my State are facing tough economic challenges, but they are meeting them head-on. Wisconsin has a determined workforce that is a tremendous asset as we look to rebuild this economy. These talented, hard-working people are ready, willing, and able to work, and Congress should be doing more to help connect them with jobs in growing industries.

That is exactly what I am proposing to do as I introduce this Community-Based Health Care Retraining Act. This bill will help more dislocated workers find jobs in the growing health care industry. My bill would create $25 million in grants to help workforce development boards in our communities identify health care job openings and train people for these positions. This bill is also paid for, so it won't increase the deficit. This bill is a small step toward two critically important goals: helping the hard-working Americans whose jobs have disappeared and providing all Americans with the health care they deserve.

The Community-Based Health Care Retraining Act puts control in the hands of the local communities. It allows local workforce development boards to partner with institutions of higher education and other community leaders to design programs that can retrain dislocated workers for jobs in the health care industry. Allowing the local workforce boards and their partners to apply for the grant funds and design the programs means that each community can use the funds differently to address the specific needs it faces. Particularly in such challenging economic times, I think a one-size-fits-all approach will not work; communities know best about the resources they need to run an efficient program. I believe the Federal programs should be flexible enough to allow partnerships to tailor the programs to meet the needs of individual communities.

For years, despite limited resources and increases in demand for their services, our workforce development boards have worked tirelessly to retrain workers for new employment. These boards are a tremendous asset for local economies, bringing together members of the labor, business, education, and other communities to ensure that the boards are doing their best to provide the most valuable services and training. In Wisconsin, workforce development boards are leading the way in finding innovative solutions to retraining workers for new careers on shoestring budgets. I look forward to the long overdue reauthorization of the Workforce Investment Act this year and to the opportunity to provide better support for these boards.

I wish to take this time to commend the leaders of these boards in Wisconsin and across the country for their dedication and hard work. Workforce development agencies in Wisconsin have already been training people for health care jobs. But in these difficult times, we have to do more to support our communities in these efforts. We must do our best to ensure that communities across the country have the resources they need to help employ more dislocated workers.

As we face the challenge of helping Americans who lose jobs, we must look to industries that continue to grow and demand more workers. As many of my colleagues know, there is, in fact, a real shortage of health care workers in the United States. Congress continues to fund programs that address nursing shortages and recently provided stimulus funds for health care retraining, but we need to develop longer term and wider ranging programs. Shortages of health care professionals of all sorts pose a real threat to the health of our communities by impacting access to timely, high-quality health care.

As Congress looks forward to reforming our Nation's health care system, we must also ensure that there are enough trained professionals to provide services. According to the Bureau of Labor Statistics, we are going to need an additional 700,000 nursing aides, home health aides, and other health professionals in long-term care before the year 2016.

This bill will help provide communities with the resources they need to run retraining programs for the health professions.

Partnerships funded by the legislation will be able to use these funds for a variety of purposes, including for implementing training programs, providing tuition assistance, providing transportation assistance, and also to increase capacity for existing training programs that are already working but could use more resources.

We must ensure we are doing what we can to train laid-off Americans into fields such as health care that continue to demand more workers, and this Community-Based Health Care Retraining Act takes a small but important step toward that goal.

Mr. President, I ask unanimous consent that the text of the bill and a list of supporters be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 1173

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Community-Based Health Care Retraining Act''.

SEC. 2. HEALTH PROFESSIONS TRAINING DEMONSTRATION PROJECT.

Section 171 of the Workforce Investment Act of 1998 (29 U.S.C. 2916) is amended by adding at the end the following:

''(f) HEALTH PROFESSIONS TRAINING DEMONSTRATION PROJECT.—

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

''(A) COVERED COMMUNITY.—The term 'covered community' means a community or region—

''(i) that has experienced a significant percentage decline in rates of employment; and

''(ii)(I) that is determined by the Secretary of Health and Human Services (in consultation with the medical community) to be an area with a shortage of health care professionals described in subparagraph (C)(i); or

''(II) that is underserved by the health care structure, such as a rural community, a community with a significant minority population, or a community for which an applicant can otherwise demonstrate need for increased training for health care professionals.

''(B) COVERED WORKER.—The term 'covered worker' means an individual who—

''(i)(I) has been terminated or laid off, or who has received a notice of termination or layoff;

''(II)(aa) is eligible for or has exhausted entitlement to unemployment compensation; or

''(bb) has been employed for a duration sufficient to demonstrate, to the appropriate entity at a one-stop center referred to in section 134(c), attachment to the workforce, but is not eligible for unemployment compensation due to insufficient earnings or having performed services for an employer that were not covered under a State unemployment compensation law; and

''(III) is unlikely to return to a previous industry or occupation;

''(ii)(I) has been terminated or laid off, or has received a notice of termination or layoff, as a result of any permanent closure of, or any substantial layoff at, a plant, facility, or enterprise; or

''(II) is employed at a facility at which the employer has made a general announcement that such facility will close within 180 days; or

''(iii) is an incumbent worker employed in a health care profession, and whose training will provide an opportunity for employment of other individuals by increasing—

''(I) the number of instructors serving the covered community; or

''(II) the number of vacant positions in the covered community.

''(C) HEALTH CARE PROFESSIONAL.—The term 'health care professional'—

''(i) means an individual who is involved with—

''(I) the delivery of health care services, or related services, pertaining to—

''(aa) the identification, evaluation, management, and prevention of diseases, disorders, or injuries; or

''(bb) home-based or community-based long-term care;

''(II) the delivery of dietary and nutrition services;

''(III) the delivery of dental services; or

''(IV) rehabilitation and health systems management; and

''(ii) includes individuals in health care professions for which there is a shortage in the community involved, as determined by the Secretary of Health and Human Services (in consultation with the medical community) or as otherwise demonstrated by the applicant.

''(D) TRIBAL COLLEGE OR UNIVERSITY.—The term 'tribal college or university' means a Tribal College or University, as defined in section 316(b) of the Higher Education Act of 1965 (20 U.S.C. 1059c(b)).

''(2) ESTABLISHMENT OF PROJECT.—In accordance with subsection (b), the Secretary shall establish and carry out a health professions training demonstration project.

''(3) GRANTS.—In carrying out the project, the Secretary, after consultation with the Secretary of Health and Human Services, shall make grants to eligible entities to pay for the Federal share of the cost of enabling the entities to carry out programs in covered communities to train covered workers for employment as health care professionals (referred to in this subsection as 'training programs'). The Secretary shall make each grant in an amount of not less than $100,000 and not more than $500,000, and each such grant shall be for a period of 5 years.

''(4) ELIGIBLE ENTITIES.—Notwithstanding subsection (b)(2)(B), to be eligible to receive a grant under this subsection to carry out a training program in a covered community, an entity shall be a partnership that consists of—

''(A) a local workforce investment board established under section 117 that is serving the covered community; and

''(B) an institution of higher education, as defined in sections 101 and 102 of the Higher Education Act of 1965 (20 U.S.C. 1001, 1002), in partnership with at least 1 of the following:

''(i) A health clinic or hospital.

''(ii) A home-based or community-based long-term care facility or program.

''(iii) A health care facility administered by the Secretary of Veterans Affairs.

''(iv) A tribal college or university.

''(v) A labor organization, or an industry or industry group.

''(vi) A local economic development entity serving the covered community.

''(vii) A joint labor-management partnership.

''(5) APPLICATIONS.—To be eligible to receive a grant under this subsection, an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including, at a minimum—

''(A) a proposal to use the grant funds to establish or expand a training program in order to train covered workers for employment as health care professionals, including information that demonstrates the long-term viability of the training program beyond the period of the grant;

''(B) information demonstrating the need for the training and support services to be provided through the training program;

''(C) information describing the manner in which the entity will expend the grant funds, and the activities to be carried out with the funds;

''(D) information demonstrating that the entity meets the requirements of paragraph (4);

''(E) with respect to training programs carried out by the applicant, information—

''(i) on the graduation rates of the training programs involved;

''(ii) on the retention measures carried out by the applicant;

''(iii) on the length of time necessary to complete the training programs of the applicant; and

''(iv) on the number of qualified covered workers that are refused admittance into the training programs because of lack of capacity; and

''(F) a description of how the applicant has engaged all relevant stakeholders, including the health care industry to be served by the training program, local labor organizations and other workforce groups, and local industry, in the design of the training program to be served with grant funds.

''(6) SELECTION.—In making grants under paragraph (3), the Secretary, after consultation with the Secretary of Health and Human Services, shall—

''(A) consider the information submitted by the eligible entities under paragraph (5)(E);

''(B) select—

''(i) eligible entities submitting applications that meet such criteria as the Secretary of Labor determines to be appropriate; and

''(ii) among such entities, the eligible entities serving the covered communities with the greatest need for the grants and the greatest potential to benefit from the grants; and

''(C) give preference to eligible entities—

''(i) submitting applications to serve covered workers who have been terminated or laid off or have received a notice of termination or layoff from a manufacturing, service, or construction industry, or another industry with significant decline in employment as determined by the Secretary; and

''(ii) with a demonstrated history of similar and successful partnerships with State boards or local boards, institutions of higher education (as defined in paragraph (4)(B)), industry groups, and labor organizations.

''(7) USE OF FUNDS.—

''(A) IN GENERAL.—An entity that receives a grant under this subsection shall use the funds made available through the grant for training and support services that meet the needs described in the application submitted under paragraph (5), which may include—

''(i) implementing training programs for covered workers;

''(ii) providing support services for covered workers participating in the training programs, such as—

''(I) providing tuition assistance;

''(II) establishing or expanding distance education programs;

''(III) providing transportation assistance; or

''(IV) providing child care; or

''(iii) increasing capacity, subject to subparagraph (B), at an educational institution or training center to train individuals for employment as health professionals, such as by—

''(I) expanding a facility, subject to subparagraph (B);

''(II) expanding course offerings;

''(III) hiring faculty;

''(IV) providing a student loan repayment program for the faculty;

''(V) establishing or expanding clinical education opportunities;

''(VI) purchasing equipment, such as computers, books, clinical supplies, or a patient simulator; or

''(VII) conducting recruitment.

''(B) LIMITATION.—Any such grant funds that are used to expand facilities may only be used to rent or modernize existing facilities, not to build additional facilities. The entity shall use not less than 50 percent of the grant funds to carry out activities described in clause (i) or (ii) of subparagraph (A), unless the entity demonstrates, in the application submitted under paragraph (5), a need to spend more than 50 percent of the grant funds on activities described in subparagraph (A)(iii).

''(8) FEDERAL SHARE.—

''(A) IN GENERAL.—The Federal share of the cost described in paragraph (3) shall be—

''(i) for the first year of the grant period, 95 percent;

''(ii) for the second such year, 85 percent;

''(iii) for the third such year, 75 percent;

''(iv) for the fourth such year, 65 percent; and

''(v) for the fifth such year, 55 percent.

''(B) NON-FEDERAL SHARE.—The eligible entity shall provide the non-Federal share of the cost in cash or in kind, fairly evaluated, including plant, equipment, or services.

''(9) EVALUATION.—

''(A) IN GENERAL.—Under the Secretary's existing authority under section 172, not more than 1 percent of the funds provided under this subsection shall be used for evaluation of the training programs described in paragraph (3). Eligible entities receiving grants under this section shall use not more than 1 percent of the grant funds for purposes of evaluation or documentation of the training programs.

''(B) CONTENTS.—In conducting an evaluation under subparagraph (A), an eligible entity shall provide data detailing the success of the training program carried out by the entity under paragraph (3), including—

''(i) information on the number and percentage of participating covered workers who complete a training program, including those who earn a degree or certificate through such training programs;

''(ii) information on the rate of employment of covered workers who have completed the training program;

''(iii) an assessment of how well the needs of the health care community were addressed by the training program; and

''(iv) any other data determined to be relevant by the entity to demonstrate the success of the training program.

''(C) REPORT.—The Secretary shall compile the information resulting from the evaluation or documentation conducted under subparagraph (A), and shall submit a report to Congress containing the information.

''(10) FUNDING.—Of the amounts appropriated to, and available at the discretion of, the Secretary or the Secretary of Health and Human Services for programmatic and administrative expenditures, a total of $25,000,000 shall be used to establish and carry out the demonstration project described in paragraph (2) in accordance with this subsection.''.

Service Employees International Union (SEIU), Wisconsin Hospital Association, Wisconsin Workforce Development Association, University of Wisconsin System, Southwest Wisconsin Workforce Development Board, Workforce Development Board of South Central Wisconsin, Moraine Park Technical College, Gundersen Lutheran, American Health Care Association, South Central AHEC, Rural Wisconsin Health Cooperative, National Rural Recruitment and Retention Network (3RNet), American Indian Higher Education Consortium, Wisconsin Indianhead Technical College, Madison Area Technical College, Wisconsin Community Action Program Association (WISCAP), UMOS, Fox Valley Technical College, Columbia County Economic Development Corporation, Lakeshore Technical College, Western Technical College, Workforce Connections Inc., Blackhawk Technical College, Mid-State Technical College, Northeast Wisconsin Technical College, Southwest Technical College, Chippewa Valley Technical College, Northcentral Technical College, Gateway Technical College.

By Ms. CANTWELL (for herself, Ms. COLLINS, and Mr. WHITEHOUSE):

S. 1174. A bill to amend the Public Health Service Act and the Social Security Act to increase the number of primary care physicians and primary care providers and to improve patient access to primary care services, and for other services; to the Committee on Finance.

Ms. CANTWELL. Mr. President, I rise today to introduce the Preserving Patient Access to Primary Care Act of 2009, together with my colleagues from Maine, Senator SUSAN COLLINS, and from Rhode Island, Senator SHELDON WHITEHOUSE. As we set about the urgently important business of health care reform, we will be hearing a lot about the uninsured. But there is another urgent problem in our health care system: the underserved. We must address both problems as we set about reforming the health care system.

It does you little good to have health care insurance if the nearest primary care physician is hundreds of miles away.

This bipartisan proposal sets out a multifaceted approach to supporting and expanding our primary care workforce as well as enhancing the coordination of care within our health care system. I am grateful for the input and collaboration of key health-care stakeholders in Washington state that has helped make this legislation possible. In my state, we know it is possible to both increase health care quality while also lowering costs, all within an integrated system that places a priority on expanding our primary care workforce and protecting patients' relationships with their doctors.

A dramatic increase in the primary care physician workforce will be needed. My legislation not only addresses the needs of those individuals to whom health insurance coverage will be extended but also of those who are currently insured but who live in areas underserved by our current health care system.

I believe we can address this problem by adopting long overdue reforms to improve pay levels for primary care providers while also taking measures to ensure an adequate primary care workforce, particularly in rural areas. As more Americans gain health care coverage, the experts estimate there will be a shortage of 46,000 primary care physicians available to care for the influx of patients by the year 2025. As the need grows, the number of medical students choosing primary care is rapidly dwindling.

Detailed studies from the Center for Evaluative Clinical Sciences at Dartmouth and the Commonwealth Fund found that populations with ready access to primary care physicians realize improved health outcomes, reduced mortality, lower utilization of health care resources, and lower overall costs of care. Yet despite what we know, all across this country, we are failing to realize the benefits of primary care and

a system of having a primary care physician coordinate a patient's health care needs. This bill includes several key provisions aimed at achieving a high quality, more comprehensive integrated health system.

Specific provisions include: scholarship and loan repayment opportunities for primary care providers who serve in areas with critical shortages of primary care services. New residency positions for primary care with a focus on more opportunities to train in ambulatory care settings—including community in health centers. Increased reimbursements for primary care providers. Medicare payments for care coordination services, and bonus payments to providers who serve as integrated patient-centered medical homes. Improved access to primary care for seniors by eliminating copayments for preventives care services in Medicare.

I look forward to working with my colleagues in the Senate to ensure we make the necessary investments in our primary care workforce. Mr. President, I ask unanimous consent that the text of the bill and letters of support be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 1174

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

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

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

SEC. 2. FINDINGS.

Congress makes the following findings:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 3. DEFINITIONS.

(a) GENERAL DEFINITIONS.—In this Act:

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

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

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

(C) The monitoring and management of medications.

(D) Patient education and counseling services.

(E) Family caregiver education and counseling services.

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

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

(H) Management with the principal nonprofessional caregiver in the home.

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

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

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

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

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

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

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

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

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

(A) The field of family medicine.

(B) The field of general internal medicine.

(C) The field of geriatric medicine.

(D) The field of pediatric medicine

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

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

(A) a nurse practitioner; or

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

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

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

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

(b) PRIMARY MEDICAL CARE SHORTAGE AREA.—

(1) IN GENERAL.—In this Act, the term ''primary medical care shortage area'' or ''PMCSA'' means a geographic area with a shortage of physicians (as designated by the Secretary) in a primary care field, as designated in accordance with paragraph (2).

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

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

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

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

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

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

(c) MEDICALLY UNDERSERVED AREA.—

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

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

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

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

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

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

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

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

(d) PATIENT CENTERED MEDICAL HOME.—

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

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

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

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

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

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

(3) STANDARD SETTING AND QUALIFICATION PROCESS FOR MEDICAL HOMES.—The Secretary shall establish a process for the selection of a qualified standard setting and certification organization—

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

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

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

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

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

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

TITLE I—MEDICAL EDUCATION

SEC. 101. RECRUITMENT INCENTIVES.

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

''PART F—MEDICAL EDUCATION RECRUITMENT INCENTIVES

''SEC. 786. MEDICAL EDUCATION RECRUITMENT INCENTIVES.

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

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

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

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

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

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

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

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

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

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

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

''Subpart XI—Primary Care Medical Education

''SEC. 340I. SCHOLARSHIPS.

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

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

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

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

''(2) the individual agrees—

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

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

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

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

''(ii) two years.

''(c) AMOUNT.—

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

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

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

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

''(e) DEFINITIONS.—In this section:

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

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

''SEC. 340J. LOAN REPAYMENT PROGRAM.

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

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

''(1) the individual agrees to serve—

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

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

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

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

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

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

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

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

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

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

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

''(1) the individual agrees to serve—

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

''(B) in an area that is not a health professional shortage area (as designated under section 332), but has a critical shortage of physicians in the fields of obstetrics and gynecology or certified nurse midwives (as determined by the Secretary), respectively; and

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

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

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

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

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

''(2) a certified nurse midwife.

''SEC. 340L. REPORTS.

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

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

''(2) the number of graduates;

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

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

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

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

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

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

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

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

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

''SEC. 340M. AUTHORIZATION OF APPROPRIATIONS.

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

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

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

(b) FFEL LOANS.—Section 428(b)(1)(M)(i) of the Higher Education Act of 1965 (20 U.S.C. 1078(b)(1)(M)(i)) is amended by inserting ''unless the medical internship or residency program is in a primary care field (as defined in section 3(a)(5) of the Preserving Patient Access to Primary Care Act of 2009)'' after ''residency program''.

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

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

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

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

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

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

''(b) ANNOUNCEMENT.—The grants described in subsection (a) shall be announced through a publication in the Federal Register and

through appropriate media outlets in a manner intended to reach medical education institutions, associations, physician groups, and others who communicate with medical students.

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

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

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

''(d) USE OF FUNDS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TITLE II—MEDICAID RELATED PROVISIONS

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

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

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

''(G) Methods for improving the effectiveness and efficiency of medical assistance provided under this title and child health assistance provided under title XXI by encouraging the adoption of medical practices that satisfy the standards established by the Secretary under paragraph (2) of section 3(d) of the Preserving Patient Access to Primary Care Act of 2009 for medical practices to qualify as patient centered medical homes (as defined in paragraph (1) of such section).''; and

(2) in paragraph (4)—

(A) in subparagraph (A)—

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

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

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

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

(B) in subparagraph (B), by striking the second and third sentences and inserting the following: ''Such method shall provide that 100 percent of such funds for each of fiscal years 2010, 2011, and 2012 shall be allocated among States that design programs to adopt the innovative methods described in paragraph (2)(G), with preference given to States that design programs involving multipayers (including under title XVIII and private health plans) test projects for implementation of the elements necessary to be recognized as a patient centered medical home practice under the National Committee for Quality Assurance Physicians Practice Connection-PCMH module (or any other equivalent process, as determined by the Secretary).''.

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

TITLE III—MEDICARE PROVISIONS

Subtitle A—Primary Care

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

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

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

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

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

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

''(II) MECHANISM TO DETERMINE APPLICATION OF INCREASE.—The Secretary shall establish a mechanism for determining which relative value units established under this paragraph for physicians' services shall be subject to an adjustment under clause (ii)(I) as a result of the increase under subclause (I).

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

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

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

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

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

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

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

''(4) DEFINITIONS.—

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

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

''(i) Care plan oversight.

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

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

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

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

''(vi) Anticoagulation management services.

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

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

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

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

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

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

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

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

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

''Patient Centered Medical Home Services

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

''(2) The term 'qualified patient centered medical home' means a patient centered medical home (as defined in section 3(d) of the Preserving Patient Access to Primary Care Act of 2009).''.

(c) MONTHLY FEE FOR PATIENT CENTERED MEDICAL HOME SERVICES.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended by adding at the end the following new subsection:

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

''(1) MONTHLY FEE.—

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

''(B) CONSIDERATIONS.—The Secretary shall take into account the results of the Medicare medical home demonstration project under section 204 of the Medicare Improvement and Extension Act of 2006 (42 U.S.C. 1395b–1 note; division B of Public Law 109–432) in establishing the payment methodology under subparagraph (A).

''(2) AMOUNT OF PAYMENT.—

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

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

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

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

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

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

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

''(3) FUNDING.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(B) Service-specific bonus payments.

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

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

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

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

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

''(3) FUNDING.—

''(A) DETERMINATION.—The Secretary shall determine the aggregate estimated savings for a calendar year as a result of such increased payments on reducing preventable hospital admissions, duplicate testing, medication errors and drug interactions, Intensive Care Unit admissions, per capita health care expenditures, and other savings under this part and part A (including any savings with respect to items and services for which payment is not made under this section).

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

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

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

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

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

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

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

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

''(A) PRIMARY CARE PHYSICIAN; PRIMARY CARE PROVIDER.—The terms 'primary care physician' and 'primary care provider' have the meaning given such terms in paragraphs (6) and (7), respectively, of section 3(a) of the Preserving Patient Access to Primary Care Act of 2009.

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

in the category of office or other outpatient services, and consisting of subcategories of such procedure codes for services for both new and established patients.

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

(b) CONFORMING AMENDMENT.—Section 1834(g)(2)(B) of the Social Security Act (42 U.S.C. 1395m(g)(2)(B)) is amended by adding at the end the following sentence: ''Section 1833(x) shall not be taken into account in determining the amounts that would otherwise be paid pursuant to the preceding sentence.''.

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

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

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

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

(1) in paragraph (1)—

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

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

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

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

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

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

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

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

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

(3)(A) Whether the existing process includes equitable representation of physician medical specialties in proportion to their relative contributions toward caring for Medicare beneficiaries, as determined by the percentage of Medicare billings per specialty, percentage of Medicare encounters by specialty, or such other measures of relative contributions to patient care as determined by the Secretary; and

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

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

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

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

Subtitle B—Preventive Services

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

(a) IN GENERAL.—Section 1862(a)(1)(K) of the Social Security Act (42 U.S.C. 1395y(a)(1)(K)) is amended by striking ''more than'' and all that follows before the comma at the end and inserting ''more than one time during the lifetime of the individual''.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) COINSURANCE.—

(1) GENERAL APPLICATION.—

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

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

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

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

(iv) by inserting before the semicolon at the end the following: '', and (Y) with respect to preventive services described in subparagraphs (A) through (O) of section 1861(ddd)(3), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under the fee schedule that applies to such services under this part''.

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

(A) in paragraph (2)—

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

(ii) in subparagraph (C)—

(I) by striking clause (ii); and

(II) in clause (i)—

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

(bb) by redesignating subclauses (I) and (II) as clauses (i) and (ii), respectively, and moving such clauses 2 ems to the left; and

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

(B) in paragraph (3)—

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

(ii) in subparagraph (C)—

(I) by striking clause (ii); and

(II) in clause (i)—

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

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

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

(A) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by striking ''and diagnostic mammography'' and inserting '', diagnostic mammography, and preventive services (as defined in section 1861(ddd)(3))''.

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

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

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

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

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

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

(1) in clause (1), by striking ''items and services described in section 1861(s)(10)(A)'' and inserting ''preventive services (as defined in section 1861(ddd)(3))'';

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

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

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

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

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

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

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

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

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

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

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

Subtitle C—Other Provisions

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

(a) STUDY.—The Secretary, in consultation with physician organizations and other appropriate stakeholders, shall conduct a study on the development and implementation of mechanisms to facilitate increased efficiency relating to the role of physicians and primary care providers in Medicare beneficiaries obtaining needed prescription drugs under the Medicare prescription drug program under part D of title XVIII of the Social Security Act. Such study shall include an analysis of ways to—

(1) improve the accessibility of formulary information;

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

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

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

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

(a) STUDY.—The Secretary, in consultation with appropriate stakeholders, shall conduct a study on the development and implementation of mechanisms to promote and increase interaction between physicians or primary care providers and the families of Medicare beneficiaries, as well as other caregivers who support such beneficiaries, for the purpose of improving patient care under the Medicare program. Such study shall include an analysis of—

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

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

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

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

(a) ADDITIONAL PAYMENTS FOR PRIMARY CARE PHYSICIANS AND PRIMARY CARE PROVIDERS.—Section 1833 of the Social Security Act (42 U.S.C. 13951), as amended by section 304, is amended by adding at the end the following new subsection:

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

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

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

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

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

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

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

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

(a) STUDY.—The Secretary shall conduct a study to assess the ability of the Medicare program under title XVIII of the Social Security Act to engage in real-time claims adjudication for items and services furnished to Medicare beneficiaries.

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

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

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

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

SEC. 326. DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.

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

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

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

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

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

''(A) ADDITIONAL RESIDENCY POSITIONS.—

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

''(I) IN GENERAL.—The Secretary shall reduce the otherwise applicable resident limit for a hospital that the Secretary determines had residency positions that were unused for all 5 of the most recent cost reporting periods ending prior to the date of enactment of this paragraph by an amount that is equal to the number of such unused residency positions.

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

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

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

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

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

''(B) DISTRIBUTION.—

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

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

''(I) IN GENERAL.—Subject to subclause (II), in the case of a hospital in which the reference resident level of the hospital (as defined in clause (ii)) is greater than the otherwise applicable resident limit, the increase in the otherwise applicable resident limit

under this subparagraph shall be an amount equal to the product of the total number of additional residency positions available for distribution under subparagraph (A)(ii) and the quotient of—

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

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

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

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

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

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

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

''(iii) REFERENCE RESIDENT LEVEL.—

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

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

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

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

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

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

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

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

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

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

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

''(E) LIMITATION.—

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

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

''(F) APPLICATION OF PER RESIDENT AMOUNTS FOR PRIMARY CARE AND NONPRIMARY CARE.—With respect to additional residency positions in a hospital attributable to the increase provided under this paragraph, the approved FTE resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital.

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

(b) IME.—

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

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

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

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

''(x) For discharges occurring on or after the date of enactment of this clause, insofar as an additional payment amount under this subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(8)(B), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.''.

SEC. 327. COUNTING RESIDENT TIME IN OUTPATIENT SETTINGS.

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

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

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

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

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

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

(c) EFFECTIVE DATES; APPLICATION.—

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

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

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

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

(1) in paragraph (4)(E)—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) EFFECTIVE DATES; APPLICATION.—

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

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

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

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

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

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

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

''(I) IN GENERAL.—Subject to the succeeding provisions of this clause, the Secretary shall, by regulation, establish a process under which, in the case where a hospital with an approved medical residency program closes on or after the date of enactment of the Balanced Budget Act of 1997, the Secretary shall increase the otherwise applicable resident limit under this paragraph for other hospitals in accordance with this clause.

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

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

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

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

''(dd) Fourth, to all other hospitals.

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

''(IV) LIMITATION.—The aggregate number of increases in the otherwise applicable resident limits for hospitals under this clause shall be equal to the number of resident positions in the approved medical residency programs that closed on or after the date described in subclause (I).

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

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

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

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

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

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

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

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

TITLE IV—STUDIES

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

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

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

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

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

(b) REQUIREMENTS.—In conducting the study under subsection (a), the Secretary of Labor shall consider workforce data from the Health Resources and Services Administration, the Council on Graduate Medical Education, the Association of American Medical

Colleges, and input from physician membership organizations that represent primary care physicians.

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

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

(b) REPORT.—

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

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

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

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

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

AMERICAN COLLEGE OF
OSTEOPATHIC FAMILY PHYSICIANS,
Arlington Heights, IL, May 21, 2009.

Hon. MARIA CANTWELL,
U.S. Senate,
Washington, DC.

DEAR SENATOR CANTWELL: On behalf of the American College of Osteopathic Family Physicians (ACOFP), I am pleased to offer you our strong support for the ''Preserving Patient Access to Primary Care Act''. This legislation lays the groundwork for a much needed boost to the primary care physician workforce through reforms of both the Medicare payment system and the graduate medical education (GME) system. The ACOFP lauds your ambitious leadership on these important issues and looks forward to helping you secure enactment of this legislation.

As you are well aware, the current Medicare physician payment system neglects to recognize the value of primary care services in the health care delivery system. Studies show that access to primary health care is associated with better health outcomes and lower health care costs. We commend you on the emphasis your legislation places on addressing payment equity among physicians by increasing payments for evaluation and management services and providing bonus payments for care coordination and other tenets central to the delivery of primary care.

The ACOFP applauds the provisions included in the ''Preserving Patient Access to Primary Care Act'' to expand the Patient Centered Medical Home (PCMH). Building upon the progress made in the current Medicare demonstration projects, your legislation would require that Medicare transition to a new payment methodology to provide monthly payments to PCMH practices that provide care coordination to Medicare beneficiaries. Additionally, grants to states for inclusion of the PCMH into Medicaid and SCHIP programs will further provide patients with on-going access to coordinated care by a physician.

Over the last decade, the population of our country has increased and grown older. Increasing access to health care coverage for all Americans is at the center of the health care reform debate. We must work to ensure that our nation's physician workforce is capable of meeting future increased demand. Central to achieving this is a strong GME system.

The current Medicare payment system in the United States neglects the value of didactic experiences, training opportunities in non-hospital settings, and voluntary physician supervision of medical residents within the GME system. The ACOFP is supportive of your efforts to create new training opportunities in non-hospital settings as well as those seeking to clarify existing regulations governing non-hospital training. Recent statistics associated with career choices of medical school graduates reveal the acute need to increase our nation's supply of family physicians. The ACOFP strongly believes that by providing experiences in non-hospital settings for resident physicians, especially those in primary care specialties, increases the likelihood that they will seek practice opportunities in those settings.

Finally, the ACOFP supports your efforts to increase the number of primary care physicians through new scholarship and loan forgiveness programs. We recognize that the education debt burden carried by medical school graduates discourages students from seeking careers in public health service, seeking careers in family practice or practicing in underserved areas. According to the American Association of Colleges of Osteopathic Medicine (AACOM), the average osteopathic medical school graduate has a debt load of $168,031. Further, the average first year medical resident stipend is $44,747. Scholarships and loan forgiveness for physicians who agree to practice primary care medicine in underserved areas would allow medical school graduates to pursue careers in medical specialties based upon their individual career interests rather than their financial obligations, while additionally addressing geographic disparities in access to care.

Again, thank you for your leadership on this important legislation. The ACOFP and our members stand ready to assist you in securing enactment of this important legislation.

Respectfully,

JAN D. ZIEREN,
ACOFP President.

MAY 20, 2009.

Hon. MARIA CANTWELL,
U.S. Senate,
Washington, DC.

DEAR SENATOR CANTWELL: I am writing on behalf of the American Nurses Association (ANA) to applaud your efforts to address the shortage of primary care providers by introducing the Preserving Patient Access to Primary Care Act of 2009. ANA strongly supports this legislation because it recognizes the integral role nurses and nurse practitioners play in the delivery of primary care and helps bring the focus of our health care system back where it belongs—on the patient and the community.

The American Nurses Association is the only full-service national association representing the interests of 2.9 million registered nurses (RNs). Through our 51 constituent nursing associations, we represent RNs across the nation in all educational and practice settings. ANA believes that a health care system that is patient-centered, comprehensive, accessible, and delivers quality care for all is something that should not be a partisan or political issue.

The Preserving Patient Access to Primary Care Act of 2009 would provide scholarship and loan repayment opportunities for primary care providers who serve in areas with critical shortages of primary care services. Secondly, the bill would increase Medicare reimbursements for primary care providers, and provide Medicare payments for care coordination services, and monthly payments to practices which serve as patient centered medical homes. Moreover, the Preserving Patient Access to Primary Care Act of 2009 aims to support an interdisciplinary model in which providers, physicians and nurses, are able to practice collaboratively and to the full extent of their education and licensure on behalf of the patient.

The American Nurses Association is proud to support this legislation and we look forward to working with you and others in the health care community to ensure that your vision of strengthening primary care becomes reality.

Sincerely,

ROSE GONZALEZ,
Director, Government Affairs,
American Nurses Association.

AMERICAN OSTEOPATHIC ASSOCIATION,
Washington, DC, May 20, 2009.

Hon. MARIA CANTWELL,
U.S. Senate,
Washington, DC.

Hon. SUSAN COLLINS,
U.S. Senate,
Washington, DC.

DEAR SENATORS CANTWELL AND COLLINS: On behalf of the American Osteopathic Association (AOA) and the 64,000 osteopathic physicians it represents, I am pleased to inform you of our strong support for the ''Preserving Patient Access to Primary Care Act.'' We believe your legislation would provide a critical boost to the primary care physician workforce through innovative changes to the Medicare payment structure and graduate medical education system, among other reforms. The AOA commends your leadership on these important issues and we are committed to assisting you in securing enactment of this legislation.

We applaud the emphasis your legislation places upon improving primary care through alternative payment mechanisms. As you know, the Medicare physician payment system is fundamentally flawed and fails to recognize the value of primary care services in achieving savings through prevention and care coordination. Studies indicate that income disparities have a significant negative impact on the choice of primary care as a career. The ''Preserving Patient Access to Primary Care Act'' would promote payment equity for primary care physicians by increasing payments for evaluation and management services and providing bonus payments for other important primary services. The AOA appreciates your foresight and recognition of the long-term savings that will be realized through increased access to primary care.

The AOA strongly supports an expansion of the Patient Centered Medical Home (PCMH) through the Medicare demonstration project and grants to states for inclusion of PCMH models in their Medicaid and SCHIP programs. Your legislation provides a monthly primary care management fee for physicians who are designated the health home of a Medicare beneficiary and provide continuous

medical care. This policy is consistent with the principles of the patient-centered medical home as envisioned by the AOA. The PCMH payment policy contained in this legislation accounts for the considerable practice expenses involved in comprehensive care coordination and facilitates widespread adoption of the medical home. The AOA strongly supports this move toward a model of health care delivery that is based on an ongoing personal relationship with a physician.

Over the past 10 years our population has increased and aged, and to ensure that our nation's physician workforce is capable of meeting increased demand, we must begin to educate and train a larger cadre of physicians now. A strong graduate medical education (GME) system capable of providing training opportunities across specialties and geographic regions is central to building the physician workforce. However, these institutions are currently confronted with fierce competition from private markets, increasing costs and shrinking federal support. In addition to increasing residency training programs to meet the needs of our growing population, this legislation would appropriately permit Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) reimbursement for didactic educational activities and allow hospitals to count the time residents spend providing patient care in outpatient settings. The AOA strongly supports these provisions.

Finally, the AOA strongly supports your efforts to address the burden of the educational debt carried by many young physicians that may discourage them from seeking careers in public health service, practicing in underserved areas, or seeking careers in primary care specialties. The average osteopathic medical school graduate has a debt load of $168,031 and the average first year medical resident stipend is $44,747, making student debt a significant hardship throughout a physician's training. By providing scholarships and loan forgiveness for primary care physicians who agree to practice in underserved areas, this legislation would address geographic disparities in access to care and allow medical school graduates to pursue training opportunities in medical specialties based upon their individual career interests and talents versus their financial obligations.

Today, one in five medical students in the United States is enrolled in a college of osteopathic medicine. The current colleges of osteopathic medicine, and those set to open in the future, are located in regions that historically have had limited access to physician services. The location of current and future colleges of osteopathic medicine reflects the osteopathic profession's commitment to rural and underserved communities. We believe that our graduates and their patients will benefit greatly from the primary care policies and programs in this legislation.

Again, thank you for introducing this important legislation. The AOA and our members stand ready to assist you in promoting primary care and securing enactment of the ''Preserving Patient Access to Primary Care Act.''

Sincerely,

CARLO J. DIMARCO,
President.

By Mr. KOHL (for himself and Mr. WYDEN):

S. 1177. A bill to improve consumer protections for purchasers of long-term care insurance, and for other purposes; to the Committee on Finance.

Mr. KOHL. Mr. President, I rise today to express my support for the Confidence in Long-Term Care Insurance Act of 2009. With America aging at an unprecedented rate, and with the high and rising costs of caring for a loved one, the financing of long-term care must be addressed if we are going to get health care costs under control. I am proud to be an original cosponsor of this bill. I wish to also thank my colleague Senator WYDEN for his leadership on addressing the financing of long-term care.

We all know that long-term care is expensive. The cost of an average nursing home is nearly $75,000 per year. However, according to the Congressional Research Service, most Americans do not realize that neither Medicare nor Medicaid will cover these costs unless their household savings are nearly eliminated. States share the responsibility of providing Medicaid funding for long-term care with the federal government, and are also looking for ways to reduce their expenses. As of today, 43 states are in the process of launching ''Partnership'' programs, which provide incentives to consumers who purchase private long-term care insurance. But in the rush to ease the burden of long-term care costs on state budgets, we fear that some key concerns are being overlooked.

We have a duty to make sure these policies, which may span many decades, are financially viable. Several long-term care insurance providers have applied for TARP funds in recent months, raising questions about their solvency. In addition, many insurance companies have been raising their policyholders' monthly premiums, which can be devastating for older persons who are living on a fixed income. Many Americans living on modest or fixed incomes, who have held policies for many years, have seen premium rates double when a company encounters financial difficulties. For such consumers, the choices are stark and very limited: they can either dig deeper and pay the increased premiums, or let their policy lapse, leaving them with no coverage if they ever need care.

Last year, I was joined by several Senate and House colleagues in releasing a GAO report on whether adequate consumer protections are in place for those who purchase long-term care insurance. The report found that rate increases are common throughout the industry, and that consumer protections are uneven. While some states have adopted requirements that keep rates relatively stable, some have not, leaving consumers unprotected.

The Confidence in Long-Term Care Insurance Act takes several important steps to ensure that premiums increases are kept at a minimum, insurance agents receive adequate training, and that complaints and appeals are addressed in a timely manner. We should also make it easier for consumers to accurately compare policies from different insurance carriers, particularly with regard to what benefits are covered and whether the plan offers inflation protection. States should also have to approve materials used to market Partnership policies. The Confidence in Long-Term Care Insurance Act will institute many of these needed improvements.

In closing, I urge my colleagues to support the Confidence in Long-Term Care Insurance Act of 2009. It is estimated that two out of three Americans who reach the age of 65 will need long-term care services and supports at some point to assist them with day-to-day activities, and enable them to maintain a high-quality, independent life. Long-term care insurance is an appropriate product for many who wish to plan for a secure retirement. But we must guarantee that consumers have adequate information and protections, and that premiums won't skyrocket down the road. I thank Senator WYDEN for his commitment to ensuring we address the important issue of long-term care financing. I look forward to working with my colleagues to enact the legislation we are introducing today.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 1177

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 ''Confidence in Long-Term Care Insurance Act of 2009''.

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

TITLE I—NATIONAL MARKET SURVEY; MODEL DISCLOSURES AND DEFINITIONS; LTC INSURANCE COMPARE

SEC. 101. NAIC NATIONAL MARKET SURVEY.

(a) IN GENERAL.—The Secretary shall request the NAIC to conduct biennial reviews of the national and State-specific markets

for long-term care insurance policies and to submit biennial reports to the Secretary on the results of such reviews.

(b) CONTENT.—The Secretary shall request that the biennial reviews include, with respect to the period occurring since any prior review, analysis of the following:

(1) Information on key market parameters, including the number of carriers offering long-term care insurance, and the scope of coverage offered under those policies (such as policies offering nursing-home only benefits, policies offering comprehensive coverage, and hybrid products in which long-term care benefits are present).

(2) The number of complaints received and resolved, including benefit denials.

(3) The number of policies that are cancelled (including because of having lapsed or not being renewed) and reasons for such cancellations.

(4) The number of agents trained and the content of that training, including a description of agent training standards, the extent to which competency tests are included in such standards, and the pass and fail rates associated with such tests.

(5) The number of policyholders exhausting benefits.

(6) Premium rate increases sought by carriers and the range of the amount of the increase sought.

(7) Premium rate increases that were approved and the range of the amount of increase.

(8) The number of policyholders affected by any approved premium rate increases.

(9) Requests for exceptions to State reserving or capital requirements.

(c) TIMING FOR BIENNIAL REVIEW AND REPORT.—The Secretary shall request the NAIC to—

(1) complete the initial market review under this section not later than 2 years after the date of enactment of this Act;

(2) submit a report to the Secretary on the results of the initial review not later than December 31, 2011; and

(3) complete each subsequent biennial review and submit each subsequent biennial report not later than December 31 of each second succeeding year.

(d) CONSULTATION REQUIRED.—The Secretary shall request the NAIC to consult with State insurance commissioners, appropriate Federal agencies, issuers of long-term care insurance, States with experience in long-term care insurance partnership plans, other States, representatives of consumer groups, consumers of long-term care insurance policies, and such other stakeholders as the Secretary or the NAIC determine appropriate, to conduct the market reviews requested under this section.

(e) DEFINITIONS.—In this section and section 102:

(1) LONG-TERM CARE INSURANCE POLICY.—The term ''long-term care insurance policy''—

(A) means—

(i) a qualified long-term care insurance contract (as defined in section 7702B(b) of the Internal Revenue Code of 1986); and

(ii) a qualified long-term care insurance contract that covers an insured who is a resident of a State with a qualified State long-term care insurance partnership under clause (iii) of section 1917(b)(1)(C) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)) or a long-term care insurance policy offered in connection with a State plan amendment described in clause (iv) of such section; and

(B) includes any other insurance policy or rider described in the definition of ''long-term care insurance'' in section 4 of the model Act promulgated by the National Association of Insurance Commissioners (as adopted December 2006).

(2) NAIC.—The term ''NAIC'' means the National Association of Insurance Commissioners.

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

SEC. 102. MODEL DISCLOSURES AND DEFINITIONS.

(a) IN GENERAL.—The Secretary shall request the NAIC, in consultation with State health agencies as appropriate, to carry out the activities described in subsection (b).

(b) ACTIVITIES DESCRIBED.—The activities described in this subsection are the following:

(1) DEVELOP MODEL DISCLOSURES AND DEFINITIONS FOR MARKETING OF POLICIES.—To develop model language for marketing of long-term care insurance policies (including, as appropriate, language specific to qualified long-term care insurance contracts, partnership long-term care insurance policies, and such other contracts for coverage of long-term care services or benefits as the NAIC determines appropriate), that includes the following:

(A) CONSISTENT DEFINITIONS.—Consistent definitions for coverage of the various types of services and benefits provided under such policies, including institutional services, residential services with varying levels of assistance, such as assisted living, home care services, adult day services, and other types of home and community-based care, (as appropriate to describe the range of services and benefits offered under such policies in various States).

(B) CONSISTENT EXPLANATORY LANGUAGE.—Consistent language for use by issuers of such policies, and for agents selling such policies, in explaining the services and benefits covered under the policies and restrictions on the services and benefits.

(C) INFLATION PROTECTION OPTIONS.—A form that describes different inflation level options offered for long-term care insurance policies, including how policies with various levels of inflation protection compare in premium costs and benefits within 5-year time increments from 5 years through 30 years post-purchase.

(D) STANDARDIZED METHODOLOGY FOR CALCULATING INFLATION PROTECTION.—Standardized methodology for use by issuers to use to calculate inflation protection under such policies.

(2) ENFORCE.—To develop recommendations for enforcement of the model marketing disclosures and definitions, including standardized language for States to adopt to prohibit carriers from marketing policies within the State that do not meet the model marketing disclosures and definitions or the rate stability provisions under section 20 of the long-term care insurance model Act promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000 and as of December 2006) and any provisions of such section adopted after December 2006.

(c) PUBLIC COMMENT.—The Secretary shall request the NAIC to allow for public comment on the work of the NAIC in carrying out the activities described in subsection (b).

SEC. 103. LTC INSURANCE COMPARE.

(a) IN GENERAL.—Section 6021(d) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396p note) is amended—

(1) in paragraph (2)—

(A) in subparagraph (A)—

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

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

(iii) by adding at the end the following:

''(iv) establish an Internet directory of information regarding long-term care insurance, to be known as 'LTC Insurance Compare', that shall include the following:

''(I) Comparison tools to assist consumers in evaluating long-term care insurance policies (as defined in subparagraph (D)) with different benefits and features.

''(II) State-specific information about the long-term care insurance policies marketed in a State, including the following:

''(aa) Whether a State has promulgated rate stability provisions for all issuers of long-term care insurance policies and how the rate stability standards work.

''(bb) The rating history for issuers selling long-term care insurance policies in the State for at least the most recent preceding 5 years.

''(cc) The policy documents for each such policy marketed in the State.

''(III) Links to State information regarding long-term care under State Medicaid programs (which may be provided, as appropriate, through Internet linkages to the websites of State Medicaid programs) that includes the following:

''(aa) The medical assistance provided under each State's Medicaid program for nursing facility services and other long-term care services (including any functional criteria imposed for receipt of such services, as reported in accordance with section 1902(a)(28)(D) of the Social Security Act) and any differences from benefits and services offered under long-term care insurance policies in the State and the criteria for triggering receipt of such benefits and services.

''(bb) If the State has a qualified State long-term care insurance partnership under section 1917(b)(1)(C)(iii) of the Social Security Act, information regarding how and when an individual with a partnership long-term care insurance policy who is receiving benefits under the policy should apply for medical assistance for nursing facility services or other long-term care services under the State Medicaid program and information regarding about how Medicaid asset protection is accumulated over time under such policies.''; and

(B) by adding at the end the following:

''(C) CURRENT INFORMATION.—The Secretary of Health and Human Services shall ensure that, to the greatest extent practicable, the information maintained in the National Clearinghouse for Long-Term Care Information, including the information required for LTC Insurance Compare, is the most recent information available.

''(D) LONG-TERM CARE INSURANCE POLICY DEFINED.—In subparagraph (A)(iv), the term 'long-term care insurance policy' means a qualified long-term care insurance contract (as defined in section 7702B(b) of the Internal Revenue Code of 1986), a qualified long-term care insurance contract that covers an insured who is a resident of a State with a qualified State long-term care insurance partnership under clause (iii) of section 1917(b)(1)(C) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)) or a long-term care insurance policy offered in connection with a State plan amendment described in clause (iv) of such section, and includes any other insurance policy or rider described in the definition of 'long-term care insurance' in section 4 of the model Act promulgated by the National Association of Insurance Commissioners (as adopted December 2006).'';

(2) by redesignating paragraph (3) as paragraph (4)

(3) in paragraph (4), (as so redesignated), by inserting '', and $5,000,000 for each of fiscal years 2011 through 2013'' after ''2010''; and

(4) by inserting after paragraph (2) the following:

''(3) CONSULTATION ON LTC INSURANCE COMPARE.—The Secretary of Health and Human Services shall consult with the National Association of Insurance Commissioners and the entities and stakeholders specified in

section 101(d) of the Confidence in Long-Term Care Insurance Act of 2009 in designing and implementing the LTC Insurance Compare required under paragraph (2)(A)(iv).''.

(b) MEDICAID STATE PLAN REQUIREMENT TO SUBMIT NURSING FACILITY SERVICES FUNCTIONAL CRITERIA DATA.—Section 1902(a)(28) of the Social Security Act (42 U.S.C. 1396a(a)(28)) is amended—

(1) in subparagraph (C), by striking ''and'' after the semicolon;

(2) in subparagraph (D)(iii), by adding ''and'' after the semicolon; and

(3) by inserting after subparagraph (D)(iii), the following new subparagraph:

''(E) for the annual submission of data relating to functional criteria for the receipt of nursing facility services under the plan (in such form and manner as the Secretary shall specify);''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section take effect on the date of enactment of this Act.

(2) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary of Health and Human Services determines requires State legislation or State regulation in order for the plan to meet the additional requirements imposed by the amendments made by subsection (b), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

TITLE II—IMPROVED STATE CONSUMER PROTECTIONS FOR QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS AND MEDICAID PARTNERSHIP POLICIES

SEC. 201. APPLICATION OF MEDICAID PARTNERSHIP REQUIRED MODEL PROVISIONS TO ALL TAX-QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

(a) IN GENERAL.—Section 7702B(g)(1) of the Internal Revenue Code of 1986 (relating to consumer protection provisions) is amended—

(1) in subparagraph (A), by inserting ''(but only to the extent such requirements do not conflict with requirements applicable under subparagraph (B)),'' after ''paragraph (2)'',

(2) by redesignating subparagraphs (B) and (C) as subparagraphs (C) and (D), respectively, and

(3) by inserting after subparagraph (A), the following new subparagraph:

''(B) the requirements of the model regulation and model Act described in section 1917(b)(5) of the Social Security Act,''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to contracts issued after the date of enactment of this Act.

SEC. 202. STREAMLINED PROCESS FOR APPLYING NEW OR UPDATED MODEL PROVISIONS.

(a) SECRETARIAL REVIEW.—

(1) TAX-QUALIFIED POLICIES.—

(A) 2000 AND 2006 MODEL PROVISIONS.—Not later than 3 months after the date of enactment of this Act, the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall review the model provisions specified in subsection (c)(1) for purposes of determining whether updating any such provisions for a provision specified in section 7702B(g)(2) of the Internal Revenue Code of 1986, or the inclusion of any such provisions in such section, for purposes of an insurance contract qualifying for treatment as a qualified long-term care insurance contract under such Code, would improve consumer protections for insured individuals under such contracts.

(B) SUBSEQUENT MODEL PROVISIONS.—Not later than 3 months after model provisions described in paragraph (2) or (3) of subsection (c) are adopted by the National Association of Insurance Commissioners, the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall review the model provisions to determine whether the application of such provisions to an insurance contract for purposes of qualifying for treatment as a qualified long-term care insurance contract under section 7702B(g)(2) of the Internal Revenue Code of 1986, would improve consumer protections for insured individuals under such contracts.

(2) MEDICAID PARTNERSHIP POLICIES.—

(A) SUBSEQUENT MODEL PROVISIONS.—Not later than 3 months after model provisions described in paragraph (2) or (3) of subsection (c) are adopted by the National Association of Insurance Commissioners, the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury, shall review the model provisions to determine whether the application of such provisions to an insurance contract for purposes of satisfying the requirements for participation in a qualified State long-term care insurance partnership under section 1917(b)(1)(C)(iii) of such Act (42 U.S.C. 1396p(b)(1)(C)(iii)) would improve consumer protections for insured individuals under such contracts.

(B) REVIEW OF OTHER PARTNERSHIP REQUIREMENTS.—The Secretary of Health and Human Services, in consultation with the Secretary of the Treasury, shall review clauses (iii) and (iv) of section 1917(b)(1)(C) for purposes of determining whether the requirements specified in such clauses should be modified to provide improved consumer protections or, as appropriate, to resolve any conflicts with the application of the 2006 model provisions under paragraph (5) of section 1917(b) (as amended by section 302(a)) or with the application of any model provisions that the Secretary determines should apply to an insurance contract as a result of a review required under subparagraph (A).

(b) EXPEDITED RULEMAKING.—

(1) TAX-QUALIFIED POLICIES.—Subject to paragraph (3), if the Secretary of the Treasury determines that any model provisions reviewed under subsection (a)(1) should apply for purposes of an insurance contract qualifying for treatment as a qualified long-term care insurance contract under the Internal Revenue Code of 1986, the Secretary, shall promulgate an interim final rule applying such provisions for such purposes not later than 3 months after making such determination.

(2) MEDICAID PARTNERSHIP POLICIES.—Subject to paragraph (3), if the Secretary of Health and Human Services determines that any model provisions or requirements reviewed under subsection (a)(2) should apply for purposes of an insurance contract satisfying the requirements for participation in a qualified State long-term care insurance partnership under section 1917(b)(1)(C)(iii) of such Act (42 U.S.C. 1396p(b)(1)(C)(iii)), the Secretary, shall promulgate an interim final rule applying such provisions for such purposes not later than 3 months after making such determination.

(3) CONSULTATION REQUIRED.—The Secretary of the Treasury and the Secretary of Health and Human Services, respectively, shall consult with the National Association of Insurance Commissioners and the entities and stakeholders specified in section 101(d) regarding the extent to which it is appropriate to apply the model provisions described in paragraph (1) or (2) (as applicable) to insurance contracts described in such paragraphs through promulgation of an interim final rule. If, after such consultation—

(A) the Secretary of the Treasury determines it would be appropriate to promulgate an interim final rule, the Secretary of the Treasury shall use notice and comment rulemaking to promulgate a rule applying such provisions to insurance contracts described in paragraph (1); and

(B) the Secretary of Health and Human Services determines it would be appropriate to promulgate an interim final rule, the Secretary of Health and Human Services shall use notice and comment rulemaking to promulgate a rule applying such provisions to insurance contracts described in paragraph (2).

(4) RULE OF CONSTRUCTION RELATING TO APPLICATION OF CONGRESSIONAL REVIEW ACT.—Nothing in paragraphs (1), (2), or (3) shall be construed as affecting the application of the sections 801 through 808 of title 5, United States Code (commonly known as the ''Congressional Review Act'') to any interim final rule issued in accordance with such paragraphs.

(5) TECHNICAL AMENDMENT ELIMINATING PRIOR REVIEW STANDARD MADE OBSOLETE.—Section 1917(b)(5) of the Social Security Act (42 U.S.C. 1396p(b)(5)) is amended by striking subparagraph (C).

(c) MODEL PROVISIONS.—In this section, the term ''model provisions'' means—

(1) each provision of the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000 and as of December 2006);

(2) each provision of the model language relating to marketing disclosures and definitions developed under section 102(b)(1); and

(3) each provision of any long-term care insurance model regulation, or the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners and adopted after December 2006.

TITLE III—IMPROVED CONSUMER PROTECTIONS FOR MEDICAID PARTNERSHIP POLICIES

SEC. 301. BIENNIAL REPORTS ON IMPACT OF MEDICAID LONG-TERM CARE INSURANCE PARTNERSHIPS.

Section 6021(c) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396p note) is amended to read as follows:

''(c) BIENNIAL REPORTS.—

''(1) IN GENERAL.—Not later than January 1, 2010, and biennially thereafter, the Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall issue a report to States and Congress on the long-term care insurance partnerships established in accordance with section 1917(b)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)(ii)). Each report shall include (with respect to the period the report addresses) the following information, nationally and on a State-specific basis:

''(A) Analyses of the extent to which such partnerships improve access of individuals to affordable long-term care services and benefits and the impact of such partnerships on Federal and State expenditures on long-term care under the Medicare and Medicaid programs.

''(B) Analyses of the impact of such partnerships on consumer decisionmaking with respect to purchasing, accessing, and retaining coverage under long-term care insurance

policies (as defined in subsection (d)(2)(D)), including a description of the benefits and services offered under such policies, the average premiums for coverage under such policies, the number of policies sold and at what ages, the number of policies retained and for how long, the number of policies for which coverage was exhausted, and the number of insured individuals who were determined eligible for medical assistance under the State Medicaid program.

''(2) DATA.—The reports by issuers of partnership long-term care insurance policies required under section 1917(b)(1)(C)(iii)(VI) of the Social Security Act shall include such data as the Secretary shall specify in order to conduct the analyses required under paragraph (1).

''(3) PUBLIC AVAILABILITY.—The Secretary shall make each report issued under this subsection publicly available through the LTC Insurance Compare website required under subsection (d).

''(4) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as requiring the Secretary to conduct an independent review of each long-term care insurance policy offered under or in connection with such a partnership.

''(5) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary to carry out this subsection, $1,000,000 for the period of fiscal years 2010 through 2012.''.

SEC. 302. ADDITIONAL CONSUMER PROTECTIONS FOR MEDICAID PARTNERSHIPS.

(a) APPLICATION OF 2006 MODEL PROVISIONS.—

(1) UPDATING OF 2000 REQUIREMENTS.—

(A) IN GENERAL.—Section 1917(b)(5)(B)(i) of the Social Security Act (42 U.S.C. 1396p(b)(5)(B)(i)) is amended by striking ''October 2000'' and inserting ''December 2006''.

(B) CONFORMING AMENDMENTS.—

(i) Subclause (XVII) of such section is amended by striking ''section 26'' and inserting ''section 28''.

(ii) Subclause (XVIII) of such section is amended by striking ''section 29'' and inserting ''section 31''.

(iii) Subclause (XIX) of such section is amended by striking ''section 30'' and inserting ''section 32''.

(2) APPLICATION TO GRANDFATHERED PARTNERSHIPS.—Section 1917(b)(1)(C)(iv) of such Act (42 U.S.C. 1396p(b)(1)(C)(iv)) is amended by inserting '', and the State satisfies the requirements of paragraph (5)'' after ''2005''.

(b) APPLICATION OF PRODUCER TRAINING MODEL ACT REQUIREMENTS.—Section 1917(b)(1)(C) of such Act (42 U.S.C. 1396p(b)(1)(C)) is amended—

(1) in clause (iii)(V), by inserting ''and satisfies the producer training requirements specified in section 9 of the model Act specified in paragraph (5)'' after ''coverage of long-term care''; and

(2) in clause (iv), as amended by subsection (a)(2), by inserting ''clause (iii)(V) and'' before ''paragraph (5)''.

(c) APPLICATION OF ADDITIONAL REQUIREMENTS FOR ALL PARTNERSHIPS.—Section 1917(b) of the Social Security Act (42 U.S.C. 1396p(b)) is amended—

(1) in paragraph (1)(C)—

(A) in clause (iii)—

(i) by inserting after subclause (VII) the following new subclause:

''(VIII) The State satisfies the requirements of paragraph (6).''; and

(ii) in the flush sentence at the end, by striking ''paragraph (5)'' and inserting ''paragraphs (5) and (6)''; and

(B) in clause (iv), as amended by subsections (a)(2) and (b)(2), by striking ''paragraph (5)'' and inserting ''paragraphs (5) and (6)''; and

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

''(6) For purposes of clauses (iii)(VIII) and (iv) of paragraph (1)(C), the requirements of this paragraph are the following:

''(A) The State requires issuers of long-term care insurance policies to—

''(i) use marketing materials approved by the State for purposes of the partnership verbatim in all sales and marketing activities conducted or supported by the issuers in the State with respect to any long-term care insurance policies marketed by the issuer in the State;

''(ii) provide such materials to all agents selling long-term care insurance policies in the State;

''(iii) ensure that agent training and education courses conducted or supported by the issuers incorporate such materials;

''(iv) make such materials available to any consumer upon request, and to make such materials available to all prospective purchasers of a policy offered under a qualified State long-term care insurance partnership before submission of an application for coverage under that policy.

''(B) The State requires issuers of long-term care insurance policies to require agents to use the inflation protection comparison form developed by the National Association of Insurance Commissioners in accordance with section 102(b)(1)(C) of the Confidence in Long-Term Care Insurance Act of 2009 when selling the policies in the State.

''(C) The State requires issuers of long-term care insurance policies sold in the State to comply with the provisions of section 8 of the model Act specified in paragraph (5) relating to contingent nonforfeiture benefits.

''(D) The State enacts legislation, not later than January 1, 2012, that establishes rate stability standards for all issuers of long-term care insurance policies sold in the State that are no less stringent than the premium rate schedule increase standards specified in section 20 of the model regulation specified in paragraph (5).

''(E) The State develops, updates whenever changes are made under the State plan that relate to eligibility for medical assistance for nursing facility services or other long-term care services or the amount, duration, or scope of such assistance, and provides public, readily accessible materials that describe in clear, simple language the terms of such eligibility, the benefits and services provided as such assistance, and rules relating to adjustment or recovery from the estate of an individual who receives such assistance under the State plan. Such materials shall include a clear disclosure that medical assistance is not guaranteed to partnership policyholders who exhaust benefits under a partnership policy, and that Federal changes to the program under this title or State changes to the State plan may affect an individual's eligibility for, or receipt of, such assistance.

''(F) The State—

''(i) through the State Medicaid agency under section 1902(a)(5) and in consultation with the State insurance department, develops written materials explaining how the benefits and rules of long-term care policies offered by issuers participating in the partnership interact with the benefits and rules under the State plan under this title;

''(ii) requires agents to use such materials when selling or otherwise discussing how long-term care policies offered by issuers participating in the partnership work with potential purchasers and to provide the materials to any such purchasers upon request;

''(iii) informs holders of such policies of any changes in eligibility requirements under the State plan under this title and of any changes in estate recovery rules under the State plan as soon as practicable after such changes are made; and

''(iv) agrees to honor the asset protections of any such policy that were provided under the policy when purchased, regardless of whether the State subsequently terminates a partnership program under the State plan.

''(G) The State Medicaid agency under section 1902(a)(5) and the State insurance department enter into a memorandum of understanding to—

''(i) inform consumers about changes in long-term care policies offered by issuers participating in the partnership, changes in the amount, duration, or scope of medical assistance for nursing facility services or other long-term care services offered under the State plan, changes in consumer protections, and any other issues such agency and department determine appropriate; and

''(ii) jointly maintain a nonpublic database of partnership policyholders for purposes of facilitating coordination in eligibility determinations for medical assistance under the State plan and the provision of benefits or other services under such policies and medical assistance provided under the State plan that includes—

''(I) the number of policyholders applying for medical assistance under the State plan; and

''(II) the number of policyholders deemed eligible (and, if applicable, ineligible) for such assistance.

''(H) The State does not apply any limit to the disregard, for purposes of determining the eligibility of a partnership policyholder for medical assistance under the State plan and for purposes of exemption from the estate recovery requirements under the plan, of benefits provided under a partnership policy, including cash benefits provided for long-term care services, and benefits provided under the policy after the effective date of the policyholder's enrollment in the State plan.

''(I) The State enters into agreements with other States that have established qualified State long-term care insurance partnerships under which such States agree to provide reciprocity for policyholders under such partnerships.

''(J) The State provides guaranteed asset protection to all individuals covered under a policy offered under a qualified State long-term care insurance partnership who bought such a policy in the State or in another State with such a partnership and with which the State has a reciprocity agreement at the time of purchase.

''(K) At the option of the State, notwithstanding any limitation that would otherwise be imposed under subsection (f), the State disregards any amount of the equity interest in the home of an individual covered of policy offered under a qualified State long-term care insurance partnership for purposes of determining the individual's eligibility for medical assistance with respect to nursing facility services or other long-term care services.''.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section take effect on the date that is 1 year after the date of enactment of this Act.

(2) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its

failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

SEC. 303. REPORT TO CONGRESS REGARDING NEED FOR MINIMUM ANNUAL COMPOUND INFLATION PROTECTION.

Not later than 18 months after the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall submit a report to Congress that includes the Secretary's recommendation regarding whether legislative or other administrative action should be taken to require all long-term care insurance policies sold after a date determined by the Secretary in connection with a qualified State long-term care insurance partnership under clause (iii) of section 1917(b)(1)(C) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)) or a long-term care insurance policy offered in connection with a State plan amendment described in clause (iv) of such section, provide, at a minimum, 5 percent annual compound inflation protection, and if so, whether such requirements should be imposed on a basis related to the age of the policyholder at the time of purchase. The Secretary shall include in the report information on the various levels of inflation protection available under such long-term care insurance partnerships and the methodologies used by issuers of such policies to calculate and present various inflation protection options under such policies, including policies with a future purchase option feature.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 167—A BILL COMMENDING THE PEOPLE WHO HAVE SACRIFICED THEIR PERSONAL FREEDOMS TO BRING ABOUT DEMOCRATIC CHANGE IN THE PEOPLE'S REPUBLIC OF CHINA AND EXPRESSING SYMPATHY FOR THE FAMILIES OF THE PEOPLE WHO WERE KILLED, WOUNDED, OR IMPRISONED, ON THE OCCASION OF THE 20TH ANNIVERSARY OF THE TIANANMEN SQUARE MASSACRE IN BEIJING, CHINA FROM JUNE 3 THROUGH 4, 1989

Mr. INHOFE (for himself, Mr. BROWN, Mr. GRAHAM, Mr. KYL, Mr. MENENDEZ, Mr. VITTER, Mr. LIEBERMAN, Mr. COBURN, and Mr. WEBB) submitted the following resolution; which was referred to the Committee on Foreign Relations:

S. RES. 167

Whereas freedom of expression, assembly, association, and religion are fundamental rights that all people should be able to possess and enjoy;

Whereas, in April 1989, in a demonstration of democratic progress, thousands of students took part in peaceful protests against the communist government of the People's Republic of China in the capital city of Beijing;

Whereas, throughout the month of May 1989, the students, in peaceful demonstrations, drew more people, young and old and from all walks of life, into central Beijing to demand better democracy, basic freedoms of speech and assembly, and an end to corruption;

Whereas, from June 3 through 4, 1989, the Government of China ordered an estimated 300,000 members of the People's Liberation Army to enter Beijing and clear Tiananmen Square (located in central Beijing) by lethal force;

Whereas, by June 7, 1989, the Red Cross of China reported that the People's Liberation Army had killed more than 300 people in Beijing, although foreign journalists who witnessed the events estimate that thousands of people were killed and thousands more wounded;

Whereas more than 20,000 people in China were arrested and detained without trial, due to their suspected involvement in the protests at Tiananmen Square;

Whereas, according to the Department of State, the Government of China has worked to censor information about the massacre at Tiananmen Square by blocking Internet sites and other media outlets, along with other sensitive information that would be damaging to the Government of China;

Whereas the Government of China has continued to oppress the people of China by denying basic human rights, such as freedom of speech and religion, and suppressing minority groups;

Whereas, during the 2008 Olympic Games, the Government of China promised to provide the international media covering the Olympic Games with the same access given the media at all the other Olympic Games, but denied access to certain internet sites and media outlets in attempts to censor free speech;

Whereas the Department of State Human Rights Report for 2008 found that the Government of China had increased already severe cultural and religious suppression of ethnic minorities in Tibetan areas and the Xinjiang Uighur Autonomous Region, increased the persecution of members of Falun Gong, Christians from China, and other religious minorities, increased the detention and harassment of dissidents and journalists, and maintained tight controls on freedom of speech and the Internet;

Whereas the United States Commission on International Religious Freedom in 2009 stated, ''The Chinese government continues to engage in systematic and egregious violations of the freedom of religion or belief, with religious activities tightly controlled and some religious adherents detained, imprisoned, fined, beaten, and harassed.''; and

Whereas the China Aid Association reported that in 2007, there were 693 cases in which Christians from China were detained or arrested and 788 cases in which Christian house church groups were persecuted by the Government of China: Now, therefore, be it

Resolved, That the Senate—

(1) commends the people who have sacrificed their personal freedoms and, in the case of the people who demonstrated at Tiananmen Square in 1989, sacrificed their lives and freedom to—

(A) bring about democratic change in the People's Republic of China; and

(B) gain freedom of expression, assembly, association, and religion for the people of China;

(2) expresses its sympathy for the families of the people who were killed, wounded, or imprisoned due to their involvement in the peaceful protests in Tiananmen Square in Beijing, China from June 3 through 4, 1989;

(3) condemns the ongoing human rights abuses by the Government of China;

(4) calls on the Government of China to—

(A) release all prisoners that are—

(i) still in captivity as a result of their involvement in the events from June 3 through 4, 1989, at Tiananmen Square; and

(ii) imprisoned without cause;

(B) allow freedom of speech and access to information, especially information regarding the events at Tiananmen Square in 1989; and

(C) cease all harassment, intimidation, and imprisonment of—

(i) members of religious and minority groups; and

(ii) people who disagree with policies of the Government of China;

(5) supports efforts by free speech activists in China and elsewhere who are working to overcome censorship (including censorship of the Internet) and the chilling effect of censorship; and

(6) urges the President to support peaceful advocates of free speech around the world.

Mr. INHOFE. Mr. President, I rise today to pay tribute to a true American hero, Army Sergeant Schuyler Patch of Owasso, OK, who died on February 24, 2009 serving our Nation in Kandahar, Afghanistan. Schuyler was assigned to the 2nd Squadron, 106th Cavalry Regiment, 33rd Infantry Brigade Combat Team, in the Illinois National Guard, based out of Kewanee, IL.

Schuyler enlisted in the Oklahoma National Guard in March 2005, and volunteered to deploy in 2006 to Afghanistan. In November 2007, he transferred to the Illinois Army National Guard and volunteered a second time to deploy to Afghanistan in support of Operation Enduring Freedom. He was killed alongside four of his fellow Soldiers, when their vehicle was hit by an IED while on a joint patrol with the Afghan National Security Forces. Schuyler leaves behind his father John Patch of Illinois and mother Colleen Stevens of Owasso, Oklahoma. He also leaves behind a sister, Amber Patch and two brothers, Garrett and Seth Patch.

Schuyler was a selfless and courageous Soldier committed to this country and its freedom. His mother, Colleen, said that he died doing what he loved to do; making a difference in the world. She also expressed his love and care for the Afghan children while he was in Afghanistan. Schuyler's sister, Amber said, ''He loved everything about the Army and he believed in everything he was doing over there.'' His aunt, Julie Morland said, ''We are all very proud of him for even going over the first time and then volunteering to go over. It takes a special person to even join the Guard in the first place. To go there and fight as a volunteer, it takes a special person.''

On Schuyler's online Guest Book, I read through some of the things said about his life and character.

Schuyler's cousin wrote, ''Schuyler was not only brave, he was caring and never afraid to show his love for family and friends. A hello was never complete until he gave those he loved a hug . . . the world will be a sadder place without this fun loving, vibrant, kind, generous young man who always made me smile.''

Another friend wrote, ''He was a great guy and no one that ever knew