S. 979

At the request of Mr. DURBIN, the name of the Senator from Pennsylvania (Mr. SPECTER) was added as a cosponsor of S. 979, a bill to amend the Public Health Service Act to establish a nationwide health insurance purchasing pool for small businesses and the self-employed that would offer a choice of private health plans and make health coverage more affordable, predictable, and accessible.

S. 1019

At the request of Mr. HARKIN, the name of the Senator from Minnesota (Ms. KLOBUCHAR) was added as a cosponsor of S. 1019, a bill to amend the Internal Revenue Code of 1986 to allow a credit against income tax for the purchase of hearing aids.

S. 1023

At the request of Mr. DORGAN, the names of the Senator from Connecticut (Mr. DODD), the Senator from Vermont (Mr. SANDERS) and the Senator from Oregon (Mr. MERKLEY) were added as cosponsors of S. 1023, a bill to establish a non-profit corporation to communicate United States entry policies and otherwise promote leisure, business, and scholarly travel to the United States.

S. 1026

At the request of Mr. CORNYN, the name of the Senator from Pennsylvania (Mr. SPECTER) was added as a cosponsor of S. 1026, a bill to amend the Uniformed and Overseas Citizens Absentee Voting Act to improve procedures for the collection and delivery of marked absentee ballots of absent overseas uniformed service voters, and for other purposes.

S. 1066

At the request of Mr. SCHUMER, the names of the Senator from Minnesota (Ms. KLOBUCHAR) and the Senator from Massachusetts (Mr. KERRY) were added as cosponsors of S. 1066, a bill to amend title XVIII of the Social Security Act to preserve access to ambulance services under the Medicare program.

S. 1091

At the request of Mr. WYDEN, the name of the Senator from New Jersey (Mr. MENENDEZ) was added as a cosponsor of S. 1091, a bill to amend the Internal Revenue Code of 1986 to provide for an energy investment credit for energy storage property connected to the grid, and for other purposes.

S. 1157

At the request of Mr. CONRAD, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 1157, a bill to amend title XVIII of the Social Security Act to protect and preserve access of Medicare beneficiaries in rural areas to health care providers under the Medicare program, and for other purposes.

S. 1174

At the request of Ms. CANTWELL, the name of the Senator from Pennsylvania (Mr. SPECTER) was added as a cosponsor of 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.

S. 1214

At the request of Mr. LIEBERMAN, the name of the Senator from Alaska (Ms. MURKOWSKI) was added as a cosponsor of S. 1214, a bill to conserve fish and aquatic communities in the United States through partnerships that foster fish habitat conservation, to improve the quality of life for the people of the United States, and for other purposes.

S. 1233

At the request of Ms. LANDRIEU, the name of the Senator from New Hampshire (Mrs. SHAHEEN) was added as a cosponsor of S. 1233, a bill to reauthorize and improve the SBIR and STTR programs and for other purposes.

S. 1242

At the request of Mr. THUNE, the names of the Senator from Texas (Mrs. HUTCHISON) and the Senator from Kansas (Mr. BROWNBACK) were added as cosponsors of S. 1242, a bill to prohibit the Federal Government from holding ownership interests, and for other purposes.

S. 1253

At the request of Mr. CORKER, the names of the Senator from Kentucky (Mr. MCCONNELL) and the Senator from Iowa (Mr. GRASSLEY) were added as cosponsors of S. 1253, a bill to address reimbursement of certain costs to automobile dealers.

S.J. RES. 15

At the request of Mr. VITTER, the name of the Senator from Maine (Ms. COLLINS) was added as a cosponsor of S.J. Res. 15, a joint resolution proposing an amendment to the Constitution of the United States authorizing the Congress to prohibit the physical desecration of the flag of the United States.

S. CON. RES. 11

At the request of Ms. COLLINS, the names of the Senator from Virginia (Mr. WARNER), the Senator from North Dakota (Mr. CONRAD), the Senator from Vermont (Mr. LEAHY), the Senator from Minnesota (Ms. KLOBUCHAR) and the Senator from Hawaii (Mr. AKAKA) were added as cosponsors of S. Con. Res. 11, a concurrent resolution condemning all forms of anti-Semitism and reaffirming the support of Congress for the mandate of the Special Envoy to Monitor and Combat Anti-Semitism, and for other purposes.

S. CON. RES. 26

At the request of Mr. HARKIN, the name of the Senator from Illinois (Mr. BURRIS) was added as a cosponsor of S. Con. Res. 26, a concurrent resolution apologizing for the enslavement and racial segregation of African Americans.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. KYL (for himself, Mr. MCCONNELL, Mr. ROBERTS, and Mr. CRAPO):

S. 1259. A bill to protect all patients by prohibiting the use of data obtained from comparative effectiveness research to deny coverage of items or services under Federal health care programs and to ensure that comparative effectiveness research accounts for advancements in personalized medicine and differences in patient treatment response; to the Committee on Health, Education, Labor, and Pensions.

Mr. KYL. Mr. President, I wish to talk about a bill Senator MCCONNELL and I introduced today. I think a companion bill will also be introduced by some of the leadership in the House of Representatives. The number of the bill is S. 1259, and this bill is called the PATIENTS Act—''patient'' as in doctor-patient. The idea is to focus on health care as it relates to patients.

Health care reform should be patient centered. Nothing should come between the physician and the patient. We are concerned there is something being done that we need to stop because it could, in fact, insert government bureaucracies between the patient and the physician. What has happened is that in the stimulus bill, the Congress appropriated $1.1 billion for something called comparative effectiveness research. Comparative effectiveness research has been used for years by physicians and hospitals. Medical schools do research, and they determine what kinds of treatments are best. For example, if you have two different drugs for the same condition, they will do testing to see which one seems to work the best. It is called clinical trials. They do clinical research, and physicians and hospitals frequently use that research as recommended for the best way to treat a particular condition. It is not mandatory. Obviously, what is good for most patients may not be good for all patients. So it is not something that is obviously forced upon people, but it provides good information. The problem is that too many people now who are proposing health care reform want to use comparative effectiveness research to end up rationing care, to have a Federal entity or even a State entity, or I should say a private entity, use that research in ways that would end up rationing care, to say some care is just too expensive for you to have, and since the government is paying for it, the government is not going to give it to you.

What our bill would do is make it clear that comparative effectiveness research cannot be used to deny coverage of either a health care service or treatment by the Secretary of HHS. And we say the Secretary of Health and Human Services because all of the various entities that might do that in the Federal Government are part of HHS. So we simply prohibit the Secretary of HHS from using this comparative effectiveness research to deny

health care service or treatment. You would think that would be uncontroversial, and I am hoping at the end of the day that it is not controversial. Nobody wants their health care rationed by somebody here in Washington, DC.

It would also require that comparative effectiveness research account for differences in the preference of patients and their treatment response to personalized medicine on something called genomics.

Genomics is the breakdown of the genes in the body into all of the different elements which make us unique as individuals. What genomics research focuses on is, what exactly is it in your gene composition, the human genome, that might be different from someone else's that means that a personalized treatment would work for you whereas it might not work for someone else. They are actually finding that they can tailor specific drugs to treat specific genes in such a way that, if they know your human composition, they can find a way to treat your condition—say, a cancer—potentially slightly differently than they would treat someone else's cancer, whether it is in the dosage of the medicine or in the specific kind of medicine or however it might be—the point being that not everyone is the same. In fact, we are all different, we are all unique, and one of the things medicine must recognize is our uniqueness as individuals and not get into the habit of saying that there is a sort of a size that fits all here, and we are going to say that if doctors will treat everyone with this particular medical device or drug or treatment, then we will pay for it, but we are not going to pay for it if they do anything else. That would not be good medicine. That inserts the government between the doctor and the patient. So we say that can't be done using this comparative effectiveness research.

By the way, the bill also makes clear that nothing prohibits the FDA Commissioner from responding to drug safety concerns under his authority. Obviously, if a drug is not safe, the FDA needs to say the drug is not safe and the Federal Government is not going to pay for it. That is obvious.

But the point is that this comparative effectiveness research should not be used by the government to deny or delay or to ration care. The reason for it is, obviously, we all want to be in charge of our own health care with our doctor. We want the choice. If a doctor says: We think you need this kind of treatment and we can get coverage for that from our insurance, we want to be able to get that care. If we cannot, we want to try to find insurance that will provide that kind of coverage for us. At least at a minimum, we want to be able to pay for the treatment, if nothing else. What we do not want is for the Federal Government to say that it does not matter if you want to pay for it, it does not matter if you are covered, you cannot get it because the Federal Government says so.

This is especially important if we have a government-run insurance company, which is what many on the other side of the aisle are talking about.

The President has said he wants a so-called public option so there will be a government insurance company that will be a place where everybody could go for coverage if they don't have it. I happen to think there are better ways of getting everybody covered. To the extent we have some people who need help in getting coverage, the government can provide that help without changing the kind of coverage all the rest of us have. Surveys show, by about two to one, Americans believe we should help people get insurance who don't have it. But by the same rough numbers, everybody says: However, you don't need to affect my coverage in order to do that. In other words, I have insurance. I like it. I want to keep it. I don't want to change. I don't want to have to pay through my insurance or through having care rationed in order to make sure somebody else gets care. The bottom line is, we all want that sacred doctor-patient relationship maintained.

One might ask: Why would we be worried that this comparative effectiveness research might be used to ration care? Is there anything in the legislation that suggests this is going to happen? As it turns out, in both the bill that came from the HELP Committee and the legislation that will be drafted in the Finance Committee, there are organizations that are going to do this research that could, in fact, ration care. In the HELP Committee bill, there is a specific provision that a government entity is going to be created to conduct this research and nothing whatsoever prohibits that entity from denying care based upon the application of rationing. The same is true under the plan talked about in the Finance Committee. There a private entity is organized, but there is nothing that would prevent the Federal Government from rationing the care that is researched by the private entity.

The HELP Committee creates what it calls the agency for health care research and quality in the Department of Health and Human Services. In the Finance Committee, it is a private research entity. But in neither case is the Federal Government prohibited from using this comparative effectiveness research in rationing care.

In addition, the HELP Committee bill establishes a medical advisory council. The medical advisory council is specifically given very broad authority to make recommendations on health benefits coverage; in other words, what is covered by the Federal Government. Obviously, when the Federal Government sets rules, insurance companies frequently apply those same kind of rules. We don't want the government, rather than patients and doctors, making decisions about how much health care or what health care one would have.

Another point I have tried to make to colleagues is, if they think the Federal Government isn't considering this, think about what some people have said in the Federal Government about allocating treatment based upon cost. No less than the Acting Director of the National Institutes of Health, Raynard Kington, announced that the NIH could use this stimulus money, money in the so-called stimulus bill that pays for comparative effectiveness research, to ration care just as is done in other countries. The NIH released a list of research topics and called for the inclusion of rigorous cost effectiveness analysis because ''cost effectiveness research will provide accurate and objective information to guide future policies that support the allocation of health resources for the treatment of acute and chronic diseases.'' ''Allocation of resources'' is a euphemism for rationing of health care. Similar statements have been made by Larry Summers. Frankly, the President himself has talked about this, not in those specific terms, but in a recent interview with the New York Times he said:

> What I think government can do effectively is to be an honest broker in assessing and evaluating treatment options.

If the government is going to be a broker in treatment options, that also is a euphemism for deciding what it is going to pay for and what it will not. In other words, what one can and cannot get.

When a former Senator and at one point candidate for HHS Secretary talked about this, he acknowledged in a book he wrote that doctors and patients might resent any encroachment on their ability to use certain treatments, but he called for the same kind of body in his book that would, in effect, allocate treatments based upon this kind of cost research.

There are many others who have spoken about it as well. We know from experience that this hasn't worked out so well in countries that have tried it such as Great Britain and Canada. In fact, I will quote one other individual who has talked about this, a professor at the Harvard Business School. Regina Herzlinger said that the comparative effectiveness research in the stimulus bill could easily morph into what she called ''an instrument of health care rationing by the federal government.''

There are comparisons to what is being done in Great Britain and other European countries and Canada; ironically, at a time when those countries are actually turning away from the federal monopoly or the national monopoly because of the fact that it has resulted in rationing of care that the citizens of those countries don't like.

A former head of the American Medical Association, which has endorsed the legislation Senator MCCONNELL and I are introducing, said in an op-ed in the Chicago Tribune today, talking about the British agency, for which, ironically, the acronym is NICE:

> For example, the agency that makes these decisions in the United Kingdom determined

that we are all worth $22,750 or six months of life or $125 a day. I'm sorry. But $125 is the cost of a nice date with my wife, not the value of my life.

What he is talking about is something called quality adjusted life years which is the British definition of the value they are going to place on a life for the purpose of comparing the cost done by this cost effectiveness research to see whether the cost of the treatment outweighs the value of the life. Think about that. Let me quote from the NICE Web site. It stands for National Institute for Health and Clinical Excellence, NICE. Here is what it says on Great Britain's Web site:

With the rapid advances in modern medicine, most people accept that no publicly funded health care system, including the NHS, can possibly pay for any new medical treatment that becomes available.

If the Federal Government has a monopoly, it probably doesn't have enough money to pay for every treatment that becomes available. It goes on to say:

The enormous costs involved mean that choices have to be made.

That is why they ration care in Great Britain. It goes on:

The QALY [quality-adjusted life year] method helps us measure these factors so we can compare different treatments for the same and different conditions.

It is an idea of how much extra months or years of life of reasonable quality a person might gain as a result of the treatment.

Each drug is considered on a case-by-case basis. Generally, however, if a treatment costs more than 20,000 to 30,000 pounds per [quality-adjusted life year], then it would not be considered cost effective.

And they don't give it to you.

We have many examples of people in Great Britain who are denied care because the government has decided that the cost of the treatment is more than the quality-adjusted life year. This is adjusted for age so that the older you get, even though the treatment may cost less, you are less likely to get it because of your age. Think about that for a moment. If something costs $20,000 in the United States and you are 65 years of age and they decide that they can't afford to pay for it, is that what the United States of America is all about? Is that what our government should be telling us? Should the government have the right to say: Based on this research we have done, you can't have that treatment?

If you believe that can't happen in the United States, I think it can. It has happened in Great Britain and Canada. Our legislation says it can't. So what is the harm in adopting our legislation? That is the question I will be asking of anyone who says is it not necessary.

I want to put the question: Then what harm does it do to say that this research can't be used by the Federal Government to deny or delay treatment? I hope my colleagues will appreciate that health care is the most important thing to all of us for our families. Whatever else we may think needs to be done to reform health care, the one thing we can all agree on is, it should not result in rationing of health care for Americans. Our legislation is one step in that process. It doesn't preclude rationing of health care in other ways. But at least it says comparative effectiveness research cannot be used in order to ration care. I hope our colleagues will view this legislation as an important step we can take.

Let me give a couple examples I said I would provide. There is a fellow by the name of Rocky Fernandez, a kidney cancer patient in Britain. He was given 2 months to live when the cancer spread to his lungs. His doctor wanted to prescribe a drug called Sutent, a new drug for advanced kidney cancer, but the government said no. He and thousands of other cancer patients protested the government's decision. This is what you would have to do, I gather. The government ultimately reversed its decision and, fortunately, he was able to begin taking the drug. The British health authorities knew this wasn't the end, that as more costly life extending drugs would become available, patients would demand access to the drugs and the government would be faced with increasingly difficult decisions. So faced with a finite pot of resources, the British health authorities decided that expensive drugs like Sutent would only be approved under specific conditions: They must extend life by 3 months, and they must be used for illnesses that affect fewer than 7,000 patients a year.

Is that what we want in the United States? Before you could get a drug that would give you better quality of life or extend your life, the government is going to run through tests like this. And if it doesn't meet the test, you don't get the drug? This is the danger of a government-run system. In effect, bureaucrats in the government become health care cops. We don't want that in America.

In the reform legislation that we end up acting on, I hope we can all agree that one of the things we can do to prevent this rationing is to at least say we will do no harm. We will not allow this comparative effectiveness research to be used by the Federal Government to deny our care.

I ask unanimous consent to print in the RECORD the op-ed from the Chicago Tribune by Dr. Palmisano from which I quoted earlier.

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

[From the Chicago Tribune, June 15, 2009]

REFORM MEASURES SHOULD NOT WEAKEN OUR HEALTH CARE

(By Donald J. Palmisano)

Over the past several decades, our nation has built the finest health-care system in the world. From birth to death we value and care for life. Surgeons can perform life-saving heart surgery on a child that is still in utero. Expert trauma doctors can save the life of a mother who was badly hurt in a car crash. And end-of-life specialists can provide compassionate palliative care to seniors to ensure their last days are spent in comfort.

This didn't all just magically happen. But it could all magically go away.

Swirling around us is a great debate that will decide the future of medical care in America. There are those who desire a single-payer system, although the ''single payer'' would be the 100 million Americans who pay taxes. It would leave the government in charge of our medical choices. But since single-payer advocates know the majority of Americans oppose such a system, they have decided to advance an alternative—known as the public option.

Either approach would seriously weaken the health-care system we enjoy today. The public option would cost $1.2 trillion to $1.8 trillion to set up. Is that something our nation can afford, especially considering the latest estimates that Medicare is going to be bankrupt in 10 years?

Is it the goal of some individuals to eventually wipe out all private insurance plans and house all health care under the umbrella of the federal government? These types of government-controlled systems already exist in other countries, and all have stories of patients who had to wait months to see specialists. It's common to hear of patients who were not allowed to get the treatment their doctor prescribed because a bureaucratic decision was made on the value of their life. For example, the agency that makes these decisions in the United Kingdom determined that we are all worth $22,750 for six months of life—or $125 a day. I'm sorry, but $125 is the cost of a nice date with my wife, not the value of life.

The American Medical Association, representing more than 250,000 physicians, and an organization I once led, recently came out in opposition to the proposed public plan, saying that it ''threatens to restrict patient choice'' and that it ''would likely lead to an explosion of costs that would need to be absorbed by taxpayers.''

That position comes from studying government-controlled health care elsewhere. During my year as president of the AMA, I was able to visit and see firsthand the success and failures of other health-care systems. I recall meeting with the chairman of the British Medical Association in June 2003, when he characterized his nation's single-payer health-care system as ''the stifling of innovation by excessive, intrusive audit . . . the shackling of doctors by prescribing guidelines, referral guidelines and protocols . . . the suffocation of professional responsibility by target-setting and production line values that leave little room for the professional judgment of individual doctors or the needs of individual patients.''

And what else will happen when the government asserts its control over health care? Medical creativity, discovery and innovation—the same creativity and discovery and innovation that we have relied on for generations—will dry up. Today, millions of Americans rely on statins to reduce their risk of heart attack. The new da Vinci surgical system is already revolutionizing the way surgery is performed in operating rooms across the country. And wounded veterans are being fitted with next-generation prosthetic limbs so they can walk again.

Only in America.

We must find ways to expand access to affordable health care to the uninsured. America can solve the current problems with a system that expands insurance coverage through tax credits, consumer choice and market enhancements. However, in the process of expanding care, we cannot create a weaker system for the 80 percent of Americans who are happy with their coverage. It

would be a serious mistake to have a government-controlled micromanaged medical system that would result in diminished quality of care, long waiting lines for doctors' visits and surgical care, a lack of access to emerging technologies and the virtual end to new and hopeful medical discovery. Health care shouldn't be dictated to us by a faceless bureaucrat in Washington.

A lot is at stake as the nation engages in the health-care debate. Will we have a system that puts the patient in control with the doctor as trusted adviser, or a government-run system that ultimately rations care and stifles innovation and self-determination? I hope it's the former.

Mr. KYL. We have actually seen the danger in using this kind of research for rationing of care in another context. When we created Medicare Part D, which provides drugs to seniors, we saw the danger of rationing of drugs, and so we specifically provided, in the Medicare Modernization Act, an explicit provision that says you can't use cost-effective analysis to allocate the drugs. It is prohibited there. What we should do is take that same policy and apply it to the rest of our health care, to seniors who are on Medicare and to the rest of the population, to the extent the Federal Government will be able to dictate its care. We have not provided that same protection for any other care, and that is what our legislation, the PATIENTS Act, would do.

The final thing I wish to discuss is the notion that we can have a government-run insurance plan and that somehow that will be healthy for Americans. Stop and think, a government-run option or government option would be the Federal Government making decisions about care. So while you may decide it is a lot cheaper because the Federal Government can subsidize the insurance plan, the government will actually be deciding what kind of coverage you get. This is one of the areas we are concerned about in using this comparative effectiveness research. Because clearly the so-called public option, in order to keep costs down, could end up rationing care. That is OK if it is merely an option and people figured out, wait a minute, even though it is cheaper, I don't want this. But what Lewin and Associates, a health care consulting group, says is that unfortunately, because private employers are likely to dump their employees into the government-run system, about two-thirds of the people who have insurance today, 119 million people, would end up with the government-run plan rather than the private insurance they have today. When the President says, if you like your insurance coverage, you get to keep it, I hope what he means is that we won't do anything in our legislation to make that more difficult.

But if, in fact, the predictions of consulting groups such as Lewin come true, what will happen is, employers, faced with the situation where it is much cheaper for them to insure their employees through this government-run plan, will take 119 million people and transfer them from private insurance to government insurance. At that point, you do not have any option. So the government-run plan is not like it is an option for you, unless you want to change jobs to an employer that is willing to maintain the coverage. And those are going to be few and far between. The same thing is true with the individual health care market.

The bottom line is, when people say to you: Well, if you like your coverage, you are going to be able to keep it, that is not true. Incidentally, under the bill that is being written by the Finance Committee, that is explicitly not true either. That is why we are concerned about this. Because even though you may like the insurance you have today and say: The Federal Government can't tell me what care I can get, it will not be too much longer before that may not be true. You will have the government insurance, and it will tell you what care it can give you.

When we talk about the fact that we are eager for health reform, what we are talking about is allowing people to keep their current coverage; allowing them to take their coverage with them; that is to say, it is portable when you leave one job and you go to another job, to make sure you cannot be denied care because you have a preexisting condition; and if you need financial help in getting insurance, to find a way to provide that financial help.

We believe those are better solutions to making sure everyone is insured than providing a public option. It is a little like the government taking over General Motors. The only difference is, it is one thing if the people who are now running General Motors make a mistake. It is usually not going to be a life-or-death situation. But it is a whole new ball game if the government is deciding you cannot get a particular drug or a particular kind of surgery that your doctor says you need.

The bottom line is, Washington-run health care has significant dangers in it—more than if you are going to run the insurance companies or the car companies or the banks. When you have a Medical Advisory Council, as the HELP Committee legislation provides, or a National Institute for Health and Clinical Excellence—NICE—as in Great Britain, it is anything but nice when your health care is denied to you.

What we are trying to prevent by this legislation, for the final time, is a situation where the government is in a position to tell you that you cannot have a certain drug or treatment or device your doctor has said you need because they use this comparative effectiveness research to say: Well, in your case, you are not going to live much longer anyway. It is not cost effective for us to buy that for you.

That is not the American way. As I said, it is ironic countries such as Canada and Great Britain are actually beginning to now provide private alternatives because they know they cannot take care of all their citizens, and they know there is a revolt going on in their countries about people who are not getting the care they need. So the safety valve for that is to provide an option for the private sector to actually provide for this coverage.

Why would we want to replicate their basic mistake in so-called health care reform? There are easier, less costly, and less harmful ways to do that than the legislation that is being proposed that would allow comparative effectiveness research to ration your care.

I hope my colleagues will take a look at our legislation, S. 1259. If they would like to cosponsor it, we would love to have support because when this issue gets to the floor, we will want our colleagues to weigh in and send a very strong message that comparative effectiveness research is great but it is not good if it is used to deny care or to ration care to the American people. That we have to put an absolute stop to right now, and our legislation would do that.

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. 1259

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 ''Preserving Access to Targeted, Individualized, and Effective New Treatments and Services (PATIENTS) Act of 2009'' or the ''PATIENTS Act of 2009''.

SEC. 2. PROHIBITION ON CERTAIN USES OF DATA OBTAINED FROM COMPARATIVE EFFECTIVENESS RESEARCH; ACCOUNTING FOR PERSONALIZED MEDICINE AND DIFFERENCES IN PATIENT TREATMENT RESPONSE.

(a) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services—

(1) shall not use data obtained from the conduct of comparative effectiveness research, including such research that is conducted or supported using funds appropriated under the American Recovery and Reinvestment Act of 2009 (Public Law 111–5), to deny coverage of an item or service under a Federal health care program (as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a–7b(f))); and

(2) shall ensure that comparative effectiveness research conducted or supported by the Federal Government accounts for factors contributing to differences in the treatment response and treatment preferences of patients, including patient-reported outcomes, genomics and personalized medicine, the unique needs of health disparity populations, and indirect patient benefits.

(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as affecting the authority of the Commissioner of Food and Drugs under the Federal Food, Drug, and Cosmetic Act or the Public Health Service Act.

Mr. AKAKA (for himself, Mr. VOINOVICH, Mr. LEAHY, Mr. TESTER, Mr. BAUCUS, and Mr. CARPER):

S. 1261. A bill to repeal title II of the REAL ID Act of 2005 and amend title II

of the Homeland Security Act of 2002 to better protect the security, confidentiality, and integrity of personally identifiable information collected by States when issuing driver's licenses and identification documents, and for other purposes; to the Committee on Homeland Security and Governmental Affairs.

Mr. AKAKA. Mr. President, today I am, along with Senators VOINOVICH, LEAHY, TESTER, BAUCUS, and CARPER, introducing the Providing for Additional Security in States' Identification Act of 2009, or the PASS ID Act.

This bill represents a pragmatic approach to resolving many of the most troubling aspects of the REAL ID Act, which has been in place for the past 4 years. REAL ID was intended to implement the 9/11 Commission's recommendation for enhancing the security of drivers' licenses. I support the 9/11 Commission's recommendation, but I have been a long-time opponent of the existing REAL ID Act due to the tremendous financial burden it imposes on States and the serious privacy risks it creates.

Initially, DHS estimated the cost of implementing REAL ID to be $23 billion, of which $14 billion would be borne by the States. In the final regulations, DHS's overall cost estimate decreased to $10 billion, $4 billion of which States would have to pay. Many States are facing serious budget shortfalls and simply cannot afford this cost.

Additionally, REAL ID calls for all States to store copies of individuals' documents such as birth certificates and their photographs in databases and to provide all other State Departments of Motor Vehicles with access to that information. REAL ID does not require any privacy protection of these State databases, which would contain massive amounts of personal information. These databases could provide one-stop shopping for identity thieves and the backbone for a national identification database.

Because of these problems, the Department of Homeland Security has been forced to provide a series of extensions for compliance. All 50 States plus the District of Columbia and the territories were granted extensions until December 31, 2009. DHS may automatically grant States further extensions to May 11, 2011, if they meet certain benchmarks for compliance. Under the final regulations, complete implementation is required by December 1, 2017. Even under this drawn out timeline, it is unclear if many States will comply. Several States, including Hawaii, have passed resolutions expressing their opposition to REAL ID. Eleven States have outright rejected REAL ID, putting millions of Americans at risk of not being able to enter Federal facilities or board commercial airplanes next year if they do not meet DHS benchmarks. Americans' personal information could also be compromised if REAL ID were to fully take effect in its current form. This simply cannot be allowed to happen.

Because of my grave concerns with the REAL ID program, during the last Congress, I along with several of my colleagues introduced the Identity Security Enhancement Act, which would have repealed the REAL ID Act and replaced it with a negotiated rulemaking process that would have enhanced the security of State driver's licenses while also providing for strong privacy protections. Unfortunately, this bill did not advance, and we are now closer than ever to forcing states to ensure compliance with REAL ID.

I along with my colleagues, the Department of Homeland Security, privacy and civil liberties groups, and the National Governors Association and National Council of State Legislators—representing a broad range of views on REAL ID—have been working together to develop a bill that will address the onerous problems with REAL ID in a practical manner that can win bipartisan support. I believe that the bill we are introducing represents a pragmatic alternative to REAL ID, which will save States considerable money and address the most troubling aspects of the REAL ID Act.

The PASS ID Act does exactly what the 9/11 Commission recommended: it sets strong security standards for the issuance of identification cards and driver's licenses. What it does not do is go far beyond that recommendation by requiring the collection of Americans' personal information and storing it in a centralized repository accessible by any State government. This legislation starts with repealing the existing flawed REAL ID Act, and replaces it with a modification of the original act that peels away the most troubling aspects that add high costs without real security benefits, and implements strong new protections to protect the privacy rights of individuals.

Perhaps the most important improvement in the PASS ID Act is the removal of the mandate that States share all of their driver's license data with each of the other States. This provision created a clear risk to the privacy of all Americans' personal information and posed a great risk for identity theft and fraud. Moreover, it was this provision that raised the specter of a national database of all Americans' personal information. The PASS ID Act instead will allow States to continue to maintain their own individual databases with more stringent security requirements.

In addition, the PASS ID Act includes all of the privacy protections called for in my previous bill, the Identity Security Enhancement Act. The bill calls on the States to put procedures in place to protect information that is stored or transmitted in an electronic format. The bill also for the first time protects any machine readable data stored on identification cards and driver's licenses themselves. In particular, Social Security numbers, which are not allowed to be printed on the face of a license, would no longer be allowed to be stored in the machine readable zone, MRZ, of a license either.

Because of the ability of licenses to hold more and more electronic information, it is also important to institute important new protections for the use of the data stored on licenses. A new industry is growing up surrounding the collection and sale of data stored in MRZs for marketing purposes. Often people are not informed that their personal information is being collected and might be tracked with their purchases or sold to third parties. This bill would allow scanning of licenses to support law enforcement purposes but not for other purposes. For example, a store would be able to scan a driver's license to double check that the patron is old enough to buy alcohol, but it would not be allowed to sell the information on the card to marketers. This is an important step forward to ensure that privacy and security protections keep pace with technology, while still ensuring that the MRZ can be used for its intended purposes.

The other change that I want to point out is the clarification of Americans' right to travel on commercial aircraft and to enter Federal buildings. The current law restricts these rights by requiring a REAL ID to board commercial aircraft and to enter Federal buildings. This bill recognizes the importance of secure identification to increase the safety and security of commercial air travel and a narrower range of Federal buildings. Compliant State identification will remain the preferred method to board an aircraft, but the PASS ID Act will clarify that people cannot be denied boarding solely because they lack secure identification. The Transportation Security Administration will resolve any security concerns with people lacking a PASS ID the same way they resolve other security issues—with additional screening or other inquiries as needed. Additionally, PASS ID would narrow the secure identification requirement from all Federal buildings to only Federal facilities containing mission functions critical to homeland security, national security, or defense.

This bill does not address all of my concerns with REAL ID. Some others will be disappointed that it does not address all of their concerns. However, the reality that we face is that in less than a year, States will be required to comply with a law on the books that simply is overly burdensome and unworkable. I believe that the legislation introduced today is the best bill that can garner broad bipartisan support. It represents a strong step toward fixing the most serious shortfalls in the REAL ID Act and would introduce long-overdue, important new protections. We cannot let the perfect be the enemy of the good, especially when we are working to address a seriously flawed law already on the books.

I urge my colleagues to talk to your Governors and other State government officials, your constituents, and to privacy experts to understand just how much this legislation does to improve existing law. By taking the time to work with all stakeholders, I think that we have achieved a solution that leaves us much better off than we are today.

As always, my goal remains to ensure the privacy rights of all Americans, and I will continue to work closely with the Department of Homeland Security to ensure that privacy rights are protected fully during the implementation of PASS ID.

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. 1261

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 ''Providing for Additional Security in States' Identification Act of 2009'' or the ''PASS ID Act''.

SEC. 2. REPEAL.

Title II of the REAL ID Act of 2005 (Division B of Public Law 109–13) is repealed.

SEC. 3. IDENTIFICATION SECURITY.

(a) IN GENERAL.—Title II of the Homeland Security Act of 2002 (6 U.S.C. 121 et seq.) is amended by adding at the end the following:

''Subtitle E—Improved Security for Driver's Licenses and Personal Identification Cards

''SEC. 241. DEFINITIONS.

''In this subtitle:

''(1) DRIVER'S LICENSE.—The term 'driver's license' means a motor vehicle operator's license, as defined in section 30301 of title 49, United States Code.

''(2) IDENTIFICATION CARD.—The term 'identification card' means a personal identification card, as defined in section 1028(d) of title 18, United States Code, issued by a State.

''(3) MATERIALLY COMPLIANT.—A State is 'materially compliant' if the State has certified to the Secretary that the State has commenced issuing driver's licenses and identification cards that are compliant with the requirements of this subtitle.

''(4) OFFICIAL PURPOSE.—The term 'official purpose' means—

''(A) accessing Federal facilities that contain mission functions critical to homeland security, national security, or defense;

''(B) accessing nuclear power plants; or

''(C) boarding federally regulated commercial aircraft.

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

''(6) STATE.—The term 'State' means a State of the United States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

''SEC. 242. MINIMUM DOCUMENT REQUIREMENTS AND ISSUANCE STANDARDS FOR FEDERAL RECOGNITION.

''(a) MINIMUM STANDARDS FOR FEDERAL USE.—

''(1) IN GENERAL.—Beginning 1 year after the date on which final regulations are issued to implement this subtitle, pursuant to section 5 of the PASS ID Act—

''(A) a Federal agency may not accept, for any official purpose, a driver's license or identification card issued by a State to any person unless the State is materially compliant; and

''(B) no person shall be denied boarding a commercial aircraft solely on the basis of failure to present a driver's license or identification card issued pursuant to this subtitle.

''(2) AGENCY ACCEPTANCE.—Beginning 6 years after the date on which final regulations are issued to implement this subtitle, pursuant to section 5 of the PASS ID Act, a Federal agency may not accept, for any official purpose, a driver's license or identification card unless the license or card complies with subsection (b).

''(3) STATE CERTIFICATIONS.—The Secretary shall determine whether a State is meeting the requirements of this section based on certifications made by the State to the Secretary. Such certifications shall be made at such times and in such manner as the Secretary, in consultation with the Secretary of Transportation, may prescribe by regulation.

''(4) CERTIFICATION OF OTHER IDENTIFICATION DOCUMENTS.—The Secretary may certify any driver's license or identification card, including an Enhanced Driver's License designated by the Secretary under section 7209 of the 9/11 Commission Implementation Act of 2004, as compliant with the requirements of this subtitle if the Secretary, after review, determines such license or card meets the requirements of this subtitle.

''(b) MINIMUM DOCUMENT REQUIREMENTS.—To meet the requirements of this section, a State shall include, at a minimum, the following information and features on each driver's license and identification card issued to a person by the State:

''(1) The person's legal name.

''(2) The person's date of birth.

''(3) The person's gender.

''(4) The person's driver's license or identification card number.

''(5) A digital photograph of the person.

''(6) The person's address of principal residence, except—

''(A) as provided for under section 827 of the Violence Against Women Act (Public Law 109–162); or

''(B) for any individual who a State determines should be exempted from the requirement under this paragraph to protect the safety or security of the applicant.

''(7) The person's signature.

''(8) A combination of security features designed to protect the physical integrity of the document, including the prevention of tampering, counterfeiting, or duplication of the document for fraudulent purposes.

''(9) A common machine-readable technology, containing the data elements available on the face of a driver's license or identification card. A person's social security number may not be included in these data elements.

''(10) A unique symbol designated by the Secretary to indicate compliance with the requirements under this section.

''(c) MINIMUM ISSUANCE STANDARDS.—

''(1) IN GENERAL.—To meet the requirements of this section, for all driver's licenses and identification cards issued under this subtitle at least 1 year after the date on which final regulations are issued to implement this subtitle, pursuant to section 5 of the PASS ID Act, a State shall require, at a minimum, presentation and validation of the following information before issuing a driver's license or identification card to a person:

''(A) A photo identity document, except that a non-photo identity document is acceptable if it includes both the person's full name and date of birth.

''(B) Documentation showing the person's date of birth.

''(C) Proof of the person's social security account number or verification that the person is not eligible for a social security account number.

''(D) Documentation showing the person's name and address of principal residence.

''(2) SPECIAL REQUIREMENTS.—

''(A) IN GENERAL.—To meet the requirements of this section, a State shall comply with the minimum standards of this paragraph.

''(B) EVIDENCE OF LAWFUL STATUS.—Before issuing a driver's license or identification card to a person, a State shall verify that the person—

''(i) is a citizen or national of the United States;

''(ii) has been granted lawful permanent residence in the United States;

''(iii) has been granted asylum or withholding of removal, or has been admitted into the United States as a refugee;

''(iv) has been granted temporary residence in the United States;

''(v) has been paroled into the United States under section 212(d)(5) of the Immigration and Nationality Act (8 U.S.C. 1182(d)(5)), subject to such exceptions as the Secretary, in the Secretary's unreviewable discretion, may prescribe for aliens paroled into the United States for prosecution or other categories of paroled aliens;

''(vi) is a lawful nonimmigrant in the United States;

''(vii) has a pending application for asylum or withholding of removal and has been granted employment authorization;

''(viii) has been granted temporary protected status in the United States or has a pending application for temporary protective status and has been granted employment authorization;

''(ix) has been granted deferred action status;

''(x) has a pending application for adjustment of status to that of an alien lawfully admitted for permanent residence in the United States or conditional permanent resident status in the United States;

''(xi) has otherwise been granted employment authorization in the United States; or

''(xii) is otherwise an alien lawfully present in the United States, as determined by the Secretary in the Secretary's unreviewable discretion.

''(C) TEMPORARY DRIVER'S LICENSES AND IDENTIFICATION CARDS.—

''(i) IN GENERAL.—If a person presents evidence under any of clauses (iv) through (xii) of subparagraph (B), the State may only issue a temporary driver's license or temporary identification card to the person that is valid for a time period ending not later than the expiration date of the applicant's authorized stay in the United States or, if there is no such expiration date, for a period not to exceed 1 year. The Secretary may, in the Secretary's unreviewable discretion, authorize the issuance of temporary driver's licenses or temporary identification cards, for periods longer than 1 year, to employees of international organizations and to other nonimmigrant aliens who are authorized to remain in the United States for an indefinite period.

''(ii) DISPLAY OF EXPIRATION DATE.—A temporary driver's license or temporary identification card issued pursuant to this subparagraph shall clearly state the date on which it expires.

''(iii) RENEWAL.—A temporary driver's license or temporary identification card issued pursuant to this subparagraph may be renewed only upon verification of the applicant's current lawful status.

''(3) VALIDATION OF DOCUMENTS.—To meet the requirements of this section, a State—

''(A) shall not accept any foreign document, other than an official passport, to satisfy a requirement of paragraph (1) or (2); and

''(B) not later than 1 year after the date on which final regulations are issued to implement this subtitle, pursuant to section 5 of the PASS ID Act, shall enter into a memorandum of understanding with the Secretary to routinely utilize the automated system known as Systematic Alien Verification for Entitlements established under section 121 of the Immigration Reform and Control Act of 1986 (Public Law 99–603), to verify the legal presence status of a person, other than a United States citizen or national, who is applying for a driver's license or identification card.

''(d) OTHER REQUIREMENTS.—To meet the requirements of this section, a State shall adopt the following practices in the issuance of driver's licenses and identification cards:

''(1)(A) Employ technology to capture digital images of identity source documents so that the images can be retained in electronic storage in a transferrable format for at least as long as the applicable driver's license or identification card is valid; or

''(B) retain paper copies of source documents for at least as long as the applicable driver's license or identification card is valid.

''(2) Subject each person who submits an application for a driver's license or identification card to mandatory facial image capture.

''(3) Establish an effective procedure to confirm or verify a renewing applicant's information.

''(4) Confirm with the Social Security Administration a social security account number presented by a person using the full social security account number. In the event that a social security account number is already registered to or associated with another person to which any State has issued a driver's license or identification card, the State may use any appropriate procedures to resolve nonmatches.

''(5) Establish an effective procedure to confirm that a person submitting an application for a driver's license or identification card is terminating or has terminated any driver's license or identification card issued pursuant to this section to such person by a State.

''(6) Provide for the physical security of locations where driver's licenses and identification cards are produced and the security of document materials and papers from which driver's licenses and identification cards are produced.

''(7) Establish appropriate administrative and physical safeguards to protect the security, confidentiality, and integrity of personally identifiable information collected and maintained at locations at which driver's licenses or identification documents are produced or stored, including—

''(A) procedures to prevent the unauthorized access to, or use of, personally identifiable information;

''(B) public notice of security and privacy policies, including the use, storage, access to, and sharing of personally identifiable information;

''(C) the establishment of a process through which individuals may access, amend, and correct, as determined appropriate by the State, their own personally identifiable information.

''(8) Subject all persons authorized to manufacture or produce driver's licenses and identification cards to appropriate security clearance requirements.

''(9) Establish fraudulent document recognition and document validation training programs for appropriate employees engaged in the issuance of driver's licenses and identification cards.

''(10) Limit the period of validity of all driver's licenses and identification cards that are not temporary to a period that does not exceed 8 years.

''(e) EXCEPTIONS PROCESS.—

''(1) IN GENERAL.—States shall establish an exceptions process to reasonably accommodate persons who, for extraordinary reasons beyond their control, are unable to present the necessary documents listed in subsection (c)(1).

''(2) ALTERNATIVE DOCUMENTS.—Alternative documents accepted under an exceptions process established pursuant to paragraph (1) may not be used to demonstrate lawful presence under subsection (c)(2) unless such documents establish that the person is a citizen or national of the United States.

''(3) REPORT.—States shall include a report on the use of exceptions made under this subsection, which shall not include any personally identifiable information, as a component of the certification required under subsection (a)(3).

''(f) USE OF FEDERAL SYSTEMS.—States shall not be required to pay fees or other costs associated with the use of the automated systems known as Systematic Alien Verification for Entitlements and Social Security On-Line Verification, or any other Federal electronic system, in connection with the issuance of driver's licenses or identification cards, in accordance with this subtitle.

''(g) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to prohibit a State from issuing driver's licenses and identification cards that do not comply with the requirements of this section.

''SEC. 243. USE OF FALSE DRIVER'S LICENSE AT AIRPORTS.

''(a) IN GENERAL.—The Secretary shall enter, into the appropriate aviation security screening database, appropriate information regarding any person convicted of using a false driver's license at an airport.

''(b) DEFINITIONS.—In this section:

''(1) AIRPORT.—The term 'airport' has the meaning given such term under section 40102 of title 49, United States Code.

''(2) FALSE.—The term 'false' has the meaning given such term under section 1028(d) of title 18, United States Code.

''SEC. 244. GRANTS TO STATES.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—There is established a State Driver's License Enhancement Grant Program to award grants to assist States in conforming to the minimum standards set forth in this subtitle.

''(2) DISTRIBUTION OF GRANTS.—The Secretary, through the Administrator of the Federal Emergency Management Agency, shall distribute grants awarded under this section to States that submit an application as follows:

''(A) PROPORTIONAL ALLOCATION.—Not less than ⅔ of the amounts appropriated for grants under this section shall be allocated to each State in the ratio that—

''(i) the number of driver's licenses and identification cards issued by such State in the most recently ended calendar year; bears to

''(ii) the number of driver's licenses and identifications cards issued by all States in the most recently ended calendar year.

''(B) REMAINING ALLOCATION.—The Secretary may allocate to States any amounts appropriated for grants under this section that are not allocated under subparagraph (A) in such manner as, in the Secretary's discretion, will most effectively assist in achieving the goals of this subtitle.

''(C) MINIMUM ALLOCATION.—In allocating funds under this section, the Secretary shall ensure that for each fiscal year—

''(i) except as provided under clause (ii), each State receives not less than an amount equal to 0.35 percent of the total funds appropriated for grants under this section for that fiscal year; and

''(ii) American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, and the Virgin Islands each receive not less than an amount equal to 0.08 percent of the total funds appropriated for grants under this section for that fiscal year.

''(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary, for each of the fiscal years 2010 through 2015, such sums as may be necessary to carry out this section.

''SEC. 245. STATE-TO-STATE ONE DRIVER, ONE LICENSE DEMONSTRATION PROJECT.

''(a) ESTABLISHMENT.—The Secretary, in consultation with the Secretary of Transportation, shall establish a State-to-State 1 driver, 1 license demonstration project.

''(b) PURPOSE.—The demonstration project established under this section shall include an evaluation of the feasibility of establishing an electronic system to verify that an applicant for a driver's license or identification card issued in accordance with this subtitle does not retain a driver's license or identification card issued in accordance with this subtitle by another State.

''(c) REQUIREMENTS.—The demonstration project shall include a review of—

''(1) the costs affiliated with establishing and maintaining an electronic records system;

''(2) the security and privacy measures necessary to protect the integrity and physical security of driver's licenses; and

''(3) the appropriate governance structure to ensure effective management of the electronic records system, including preventing the unauthorized use of information in the system, and ensuring the security and confidentiality of personally identifiable information.

''(d) SAVINGS PROVISION.—Nothing in this section may be construed to—

''(1) authorize the creation of a national database of driver's license information; or

''(2) authorize States direct access to the motor vehicle database of another State.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary for each of the fiscal years 2010 through 2012 such sums as may be necessary to carry out this section.

''SEC. 246. AUTHORITY.

''(a) PARTICIPATION OF SECRETARY OF TRANSPORTATION AND STATES.—All authority to issue regulations, set standards, and issue grants under this subtitle shall be carried out by the Secretary, in consultation with the Secretary of Transportation and the States.

''(b) EXTENSIONS OF DEADLINES.—The Secretary may grant to a State an extension of time to meet the requirements of section 242(a)(1) if the State provides adequate justification for noncompliance.

''SEC. 247. LIMITATION ON STATUTORY CONSTRUCTION.

''Nothing in this subtitle may be construed to—

''(1) affect the authorities or responsibilities of the Secretary of Transportation or the States under chapter 303 of title 49, United States Code; or

''(2) preempt State privacy laws that are more protective of personal privacy than the requirements of this subtitle or the standards or regulations promulgated to implement this subtitle, provided that such State laws are consistent with this subtitle and

the regulations prescribed pursuant to this subtitle.''.

(b) TECHNICAL AMENDMENT.—Section 1(b) of the Homeland Security Act of 2002 (Public Law 107–296) is amended by inserting after the item relating to section 235 the following:

''Subtitle E—Improved Security for Driver's Licenses and Personal Identification Cards

''Sec. 241. Definitions.
''Sec. 242. Minimum document requirements and issuance standards for Federal recognition.
''Sec. 243. Use of false driver's license at airports.
''Sec. 244. Grants to States.
''Sec. 245. State-to-State one driver, one license demonstration project.
''Sec. 246. Authority.
''Sec. 247. Limitation on statutory construction.''.

SEC. 4. USE OF DRIVER'S LICENSE OR IDENTIFICATION CARD DATA BY PRIVATE ENTITIES.

Chapter 123 of title 18, United States Code is amended—

(1) in section 2722, by adding at the end the following:

''(c) COPYING INFORMATION FROM DRIVERS LICENSES OR IDENTIFICATION CARDS.—It shall be unlawful for any person, knowingly and without lawful authority—

''(1) to scan the information contained in the machine readable component of a driver's license or identification card; or

''(2)(A) to resell, share or trade that information with any other third parties;

''(B) track the use of a driver's license or identification card; or

''(C) store the information collected.'';

(2) in section 2724(a), by inserting ''driver's license, or identification card,'' after ''motor vehicle record,'';

(3) in section 2725—

(A) by redesignating paragraph (2) as paragraph (6), and adding ''and'' at the end;

(B) by redesignating paragraph (3) as paragraph (7);

(C) by redesignating paragraph (4) as paragraph (3), and striking ''and'' at the end;

(D) by redesignating paragraph (5) as paragraph (2), and striking the period at the end and inserting a semicolon;

(E) by redesignating paragraph (1) as paragraph (5);

(F) by inserting before paragraph (2), as redesignated, the following:

''(1) 'driver's license' means a motor vehicle operator's license, as defined in section 30301 of title 49, United States Code;''; and

(G) by inserting after paragraph (3), as redesignated, the following:

''(4) 'identification card' means a personal identification card, as defined in section 1028(d) of title 18, United States Code, issued by a State.''.

SEC. 5. RULEMAKING.

(a) IN GENERAL.—Not later than 9 months after the date of the enactment of this Act, the Secretary, after providing notice and an opportunity for public comment shall issue final regulations to implement subtitle E of title II of the Homeland Security Act of 2002, as added by section 3.

(b) CONTENT.—The regulations issued pursuant to subsection (a)—

(1) shall include procedures and requirements that—

(A) protect the privacy rights of individuals who apply for and hold a driver's license or personal identification card;

(B) protect the constitutional rights and civil liberties of individuals who apply for and hold a driver's licenses or personal identification card;

(2) shall include procedures to protect any personally identifiable information electronically transmitted;

(3) shall establish a process through which individuals may access, amend, and correct, as determined appropriate by the Secretary, their own personally identifiable information in any Federal databases used in complying with this Act;

(4) may not require a single design or numbering system to which driver's licenses or personal identification cards issued by all States shall conform; and

(5) shall only apply to driver's licenses or identification cards issued pursuant to subtitle E of title II of the Homeland Security Act of 2002, as added by section 3.

SEC. 6. SAVINGS PROVISION.

(a) EFFECT OF REPEAL.—Nothing in section 2 shall affect the amendment or the repeal set forth in sections 203(a) and 206 of the REAL ID Act of 2005.

(b) EFFECT OF COMPLETED ADMINISTRATIVE ACTIONS.—Completed personnel actions, agreements, grants, and contracts undertaken by an agency—

(1) shall not be affected by any provision of this Act, or any amendment made by this Act; and

(2) shall continue in effect according to their terms until amended, modified, superseded, terminated, set aside, or revoked by an officer of the United States, by a court of competent jurisdiction, or by operation of law.

By Ms. CANTWELL:

S. 1262. A bill to amend title VII of the Public Health Service Act and titles XVIII and XIX of the Social Security Act to provide additional resources for primary care services, to create new payment models for services under Medicare, to expand provision of non-institutionally-based long-term services, and for other purposes; to the Committee on Finance.

Ms. CANTWELL. Mr. President, I rise today to introduce the Medical Efficiency and Delivery Improvement of Care Act, MEDIC, a bill which provides common-sense solutions to many of the most critical problems besetting our health care system. As we embark on reforming health care in America, we are faced with restructuring a system as complex as it is important—a system which includes not only doctors and patients but medical schools, nursing homes, hospitals and community health centers. While every piece of the health care puzzle requires individual attention, one common thread connects them all: the need for improved efficiency among providers though increased access to primary care physicians. They are the ones who can provide coordinated care for patients, leading to better quality and a more efficient system. That is why I am introducing this bill as a vehicle for proposals which increase the efficiency and coordination across the health care spectrum to improve health and save money.

In my State of Washington doctors and hospitals provide some of the a highest quality and most cost-efficient care in the nation. However, instead of rewarding our State for reining in unnecessary costs and improving the health of patients, the current system actually penalizes them. Under the current fee-for-service structure we have today, health care providers are rewarded for maximizing the number of services they provide rather than focusing primarily on health outcomes. This provides a financial disincentive to efficient care because such efficiencies actually result in decreased payments. My bill addresses this issue by linking physician payments to the quality of care they provide, not the amount of services they perform. At the same time, the bill recognizes the need to allow for the differences in the cost of doing business across different regions. The resulting policy creates a fair payment system that increases the overall quality of care while resulting in a savings of $55 billion a year off the Medicare rolls.

The backbone of our health care system is comprised of the men and women who devote their lives to the practice of medicine. While our nation's physician workforce is the best in the world, current policies have left our primary care network woefully lacking, leaving many families—especially those in rural areas—without access to basic care. As few as 2 percent of medical students opt for careers in family medicine and general surgery primarily due to the low pay associated with such specialties. Therefore, a fundamental goal of reform must be expanding the primary care workforce. My legislation includes provisions which provide financial incentives for medical students and teaching hospitals—such as interest-free loans and scholarships for students going into primary care, and increased funding for small and rural hospitals to improve their primary care residency programs. The bill also calls for increasing payments to primary care physicians currently in practice. These policies will result in an improved primary care infrastructure throughout the nation, providing for quality primary care today and well into the future.

Finally, we cannot address health care reform without addressing the needs the individuals who require it the most: those in long-term care. For many older Americans and people with disabilities, long-term care is not a luxury but a necessity, a required service needed to maintain their overall quality of life. Traditionally this care has been provided in institutions such as nursing homes, which can cost upwards of $70,000 a year. While some people require the around-the-clock care provided in nursing homes, many of those in need of long-term care would be better off remaining in their homes where they can continue to be active members of the community. Home- and community-based services provide people the care they need in non-institutional settings, which, in addition to saving a significant amount of money, allows for the freedom and independence to which people are accustomed. This legislation contains several provisions which provide States with the resources they need to move away from institutional long-term care and towards home- and community-based

services, such as increasing Federal Medicaid dollars to transition to home- and community-based services, and providing incentives to create consolidated information centers so consumers and their families can make well-informed decisions about long-term care options. If we gave just 5 percent of those who go into nursing homes the ability to receive care in their own homes and communities, the Federal Government would see a net savings of more than $10 billion over 5 years. This significant savings can be achieved while simultaneously providing better care; a truly win-win situation.

In introducing this bill I am reminding my colleagues that reforming health care need not be a zero-sum game. We can achieve our goals of improving the health care workforce, stabilizing the physician payment structure, improving access to needed care and decreasing the financial and emotional burdens associated with long-term care while simultaneously providing significant savings throughout the health care system. I look forward to working with my colleagues in the Senate to ensure these crtical reforms are enacted.

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. 1262

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 ''Medical Efficiency and Delivery Improvement of Care Act (MEDIC) of 2009''.

SEC. 2. TABLE OF CONTENTS.

The table of contents for this Act is as follows:

TITLE I—LOAN PROGRAM PROVISIONS

SEC. 1001. SHORT TITLE.

This title may be cited as the ''Physician Workforce Enhancement Act of 2009''.

SEC. 1002. HOSPITAL RESIDENCY LOAN PROGRAM.

Subpart 2 of part E of title VII of the Public Health Service Act is amended by adding at the end the following new section:

''SEC. 771. HOSPITAL RESIDENCY LOAN PROGRAM.

''(a) ESTABLISHMENT.—Not later than January 1, 2010, the Secretary, acting through the Administrator of the Health Resources and Services Administration, shall establish a loan program that provides loans to eligible hospitals to establish residency training programs.

''(b) APPLICATION.—-No loan may be provided under this section to an eligible hospital except pursuant to an application that is submitted and approved in a time, manner, and form specified by the Administrator of the Health Resources and Services Administration. A loan under this section shall be on such terms and conditions and meet such requirements as the Administrator determines appropriate, in accordance with the provisions of this section.

''(c) ELIGIBILITY; PREFERENCE FOR RURAL AND SMALL URBAN AREAS.—

''(1) ELIGIBLE HOSPITAL DEFINED.—For purposes of this section, an 'eligible hospital' means, with respect to a loan under this section, a hospital that, as of the date of the submission of an application under subsection (b), meets, to the satisfaction of the Administrator of the Health Resources and Services Administration, each of the following criteria:

''(A) The hospital does not operate a residency training program, has not previously operated such a program, and has not taken any significant action, such as the expenditure of a material amount of funds, before July 1, 2009, to establish such a program.

''(B) The hospital has secured initial accreditation by the American Council for Graduate Medical Education or the American Osteopathic Association.

''(C) The hospital provides assurances to the satisfaction of the Administrator of the Health Resources and Services Administration that such loan shall be used, consistent

with subsection (d), only for the purposes of establishing and conducting an allopathic or osteopathic physician residency training program in at least one of the following medical specialties, or a combination of the following:

''(i) Family medicine.

''(ii) Internal medicine.

''(iii) Emergency medicine.

''(iv) Obstetrics or gynecology.

''(v) General surgery.

''(vi) Preventive Medicine.

''(vii) Pediatrics.

''(viii) Behavioral and Mental Health.

''(D) The hospital enters into an agreement with the Administrator that certifies the hospital will provide for the repayment of the loan in accordance with subsection (e).

''(2) PREFERENCE FOR RURAL AND SMALL AREAS.—In making loans under this section, the Administrator of the Health Resources and Services Administration shall give preference to any applicant for such a loan that is a hospital located in a rural areas (as such term is defined in section 1886(d)(2)(D) of the Social Security Act) or an urban area that is not a large urban area (as such terms are respectively defined in such section).

''(d) PERMISSIBLE USES OF LOAN FUNDS.—A loan provided under this section shall be used, with respect to a residency training program, only for costs directly attributable to the residency training program, except as otherwise provided by the Administrator of the Health Resources and Services Administration.

''(e) REPAYMENT OF LOANS.—

''(1) REPAYMENT PLANS.—For purposes of subsection (c)(1)(D), a repayment plan for an eligible hospital is in accordance with this subsection if it provides for the repayment of the loan amount in installments, in accordance with a schedule that is agreed to by the Administrator of the Health Resources and Services Administration and the hospital and that is in accordance with this subsection.

''(2) COMMENCEMENT OF REPAYMENT.—Repayment by an eligible hospital of a loan under this section shall commence not later than the date that is 18 months after the date on which the loan amount is disbursed to such hospital.

''(3) REPAYMENT PERIOD.—A loan made under this section shall be fully repaid not later than the date that is 24 months after the date on which the repayment is required to commence.

''(4) LOAN PAYABLE IN FULL IF RESIDENCY TRAINING PROGRAM CANCELED.—In the case that an eligible hospital borrows a loan under this section, with respect to a residency training program, and terminates such program before the date on which such loan has been fully repaid in accordance with a plan under paragraph (1), such loan shall be payable by the hospital not later than 45 days after the date of such termination.

''(f) NO INTEREST CHARGED.—The Administrator of the Health Resources and Services Administration may not charge or collect interest on any loan made under this section.

''(g) LIMITATION ON TOTAL AMOUNT OF LOAN.—The cumulative dollar amount of a loan made to an eligible hospital under this section may not exceed $1,000,000.

''(h) PENALTIES.—The Administrator of the Health Resources and Services Administration shall establish penalties to which an eligible hospital receiving a loan under this section would be subject if such hospital is in violation of any of the criteria described in subsection (c)(1).

''(i) REPORTS.—Not later than January 1, 2014, and annually thereafter (before January 2, 2020), the Administrator of the Health Resources and Services Administration shall submit to Congress a report on the efficacy of the program under this section in increasing the number of residents practicing in each medical specialty described in subsection (c)(1)(C) during such year and the extent to which the program resulted in an increase in the number of available practitioners in each of such medical specialties that serve medically underserved populations.

''(j) FUNDING.——

''(1) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of providing amounts for loans under this section, there are authorized to be appropriated $25,000,000 for the period of fiscal years 2010 through 2020.

''(2) AVAILABILITY.—Amounts appropriated under paragraph (1) shall remain available until expended.

''(3) REPAID LOAN AMOUNTS.—Any amount repaid by, or recovered from, an eligible hospital under this section on or before the date of termination described in subsection (k) shall be credited to the appropriation account from which the loan amount involved was originally paid. Any amount repaid by, or recovered from, such a hospital under this section after such date shall be credited to the general fund in the Treasury.

''(k) TERMINATION OF PROGRAM.—No loan may be made under this section after December 31, 2019.''.

TITLE II—PRIMARY CARE PROVISIONS

SEC. 2001. SHORT TITLE.

This title may be cited as the ''Preserving Patient Access to Primary Care Act of 2009''.

SEC. 2002. 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. 2003. DEFINITIONS.

(a) GENERAL DEFINITIONS.—In this title:

(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 title, 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 title, 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 title, 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 title.

Subtitle A—Medical Education

SEC. 2101. 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 VI—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. 2102. 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 XX—Primary Care Medical Education

''SEC. 340A. 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. 340B. 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. 340C. 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. 340D. 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. 340E. 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. 2103. 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. 2104. 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. 2105. TRAINING IN 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. 2106. 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.).

Subtitle B—Medicaid Related Provisions

SEC. 2201. 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.

Subtitle C—Medicare Provisions

PART I—PRIMARY CARE

SEC. 2301. 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. 2302. 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. 13951(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. 2303. 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 2302(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. 2304. 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. 2305. PERMANENT EXTENSION OF MEDICARE INCENTIVE PAYMENT PROGRAM FOR PHYSICIAN SCARCITY AREAS.

Section 1833(u) of the Social Security Act (42 U.S.C. 13951(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. 2306. 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 2003(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.

PART II—PREVENTIVE SERVICES

SEC. 2311. 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. 2312. 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 2302, 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. 2313. 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 2003(a)) in—

(A) furnishing appropriate preventive services (as defined in section 1861(ddd)(3) of the Social Security Act, as added by section 2312) 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.

PART III—OTHER PROVISIONS

SEC. 2321. 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. 2322. 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. 2323. IMPROVED PATIENT CARE THROUGH EXPANDED SUPPORT FOR LIMITED ENGLISH PROFICIENCY (LEP) SERVICES.

(a) ADDITIONAL PAYMENTS FOR PRIMARY CARE PHYSICIANS AND PRIMARY CARE PROVIDERS.—Section 1833 of the Social Security Act (42 U.S.C. 1395l), as amended by section 2304, 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 2003(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. 2324. 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. 2325. 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. 2326. 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. 2327. 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. 2328. 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 2327(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 2326(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. 2329. 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 2326(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. 2330. 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).

Subtitle D—Studies

SEC. 2401. 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. 2402. 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. 2403. 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.

TITLE III—MEDICARE PAYMENT PROVISIONS

SEC. 3001. SHORT TITLE.

This title may be cited as the ''Medicare Payment Improvement Act of 2009''.

SEC. 3002. FINDINGS.

Congress makes the following findings:

(1) The health care delivery system must be realigned to provide better clinical outcomes, safety, and patient satisfaction at lower cost. This should be a common goal for all health care professionals, hospitals, and other groups. Today's reimbursement system pays the most to those who perform the most services, and therefore can provide disincentives to efficient and high-quality providers.

(2) The regional inequities in Medicare reimbursement penalize areas that have cost-effective health care delivery systems and reward those States that have high utilization rates and provide inefficient care.

(3) According to the Dartmouth Health Atlas, over the past 10 years, a number of studies have explored the relationship between higher spending and the quality and outcomes of care. The findings are remarkably consistent, concluding that higher spending does not result in better quality of care.

(4) New payment models should be developed to move away from paying for quantity and instead paying for improving health and truly rewarding effective and efficient care.

SEC. 3003. VALUE INDEX UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

(a) IN GENERAL.—Section 1848(e)(5) of the Social Security Act (42 U.S.C. 1395w–4 (e)) is amended by adding at the end the following new paragraph:

''(6) VALUE INDEX.—

''(A) IN GENERAL.—The Secretary shall determine a value index for each fee schedule area. The value index shall be the ratio of the quality component under subparagraph (B) to the cost component under subparagraph (C) for that fee schedule area.

''(B) QUALITY COMPONENT.—

''(i) IN GENERAL.—The quality component shall be based on a composite score that reflects quality measures available on a State or fee schedule area basis. The measures shall reflect health outcomes and health status for the Medicare population, patient safety, and patient satisfaction. The Secretary shall use the best data available, after consultation with the Agency for Healthcare Research and Quality and with private entities that compile quality data.

''(ii) ADVISORY GROUP.—

''(I) IN GENERAL.—Not later than 60 days after the date of enactment of the Medicare Payment Improvement Act of 2009, the Secretary shall establish a group of experts and stakeholders to make consensus recommendations to the Secretary regarding development of the quality component. The membership of the advisory group shall at least reflect providers, purchasers, health plans, researchers, relevant Federal agencies, and individuals with technical expertise on health care quality.

''(II) DUTIES.—In the development of recommendations with respect to the quality component, the group established under subclause (I) shall consider at least the following areas:

''(aa) High cost procedures as determined by data under this title.

''(bb) Health outcomes and functional status of patients.

''(cc) The continuity, management, and coordination of health care and care transitions, including episodes of care, for patients across the continuum of providers, health care settings, and health plans.

''(dd) Patient, caregiver, and authorized representative experience, quality and relevance of information provided to patients, caregivers, and authorized representatives, and use of information by patients, caregivers, and authorized representatives to inform decision making.

''(ee) The safety, effectiveness, and timeliness of care.

''(ff) The appropriate use of health care resources and services.

''(gg) Other items determined appropriate by the Secretary.

''(iii) REQUIREMENT.—In establishing the quality component under this subparagraph, the Secretary shall—

''(I) take into account the recommendations of the group established under clause (ii)(I); and

''(II) provide for an open and transparent process for the activities conducted pursuant to the convening of such group with respect to the development of the quality component.

''(iv) ESTABLISHMENT.—The quality component for each fee schedule area shall be the ratio of the quality score for such area to the national average quality score.

''(v) QUALITY BASELINE.—If the quality component for a fee schedule area does not rank in the top 25th percentile as compared to the national average (as determined by the Secretary) and the amount of reimbursement for services under this section is greater than the amount of reimbursement for such services that would have applied under this section if the amendments made by section 2 of the Medicare Payment Improvement Act of 2009 had not been enacted, this section shall be applied as if such amendments had not been enacted.

''(vi) APPLICATION.—In the case of a fee schedule area that is less than an entire State, if available quality data is not sufficient to measure quality at the sub-State level, the quality component for a sub-State fee schedule area shall be the quality component for the entire State.

''(C) COST COMPONENT.—

''(i) IN GENERAL.—The cost component shall be total annual per beneficiary Medicare expenditures under part A and this part for the fee schedule area. The Secretary may use total per beneficiary expenditures under such parts in the last two years of life as an alternative measure if the Secretary determines that such measure better takes into account severity differences among fee schedule areas.

''(ii) ESTABLISHMENT.—The cost component for a fee schedule area shall be the ratio of the cost per beneficiary for such area to the national average cost per beneficiary.''.

(b) CONFORMING AMENDMENTS.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(1) in subsection (b)(1)(C), by striking ''geographic'' and inserting ''geographic and value''; and

(2) in subsection (e)—

(A) in paragraph (1)—

(i) in the heading, by inserting ''AND VALUE'' after ''GEOGRAPHIC'';

(ii) in subparagraph (A), by striking clause (iii) and inserting the following new clause:

''(iii) a value index (as defined in paragraph (6)) applicable to physician work.'';

(iii) in subparagraph (C), by inserting ''and value'' after ''geographic'' in the first sentence;

(iv) in subparagraph (D), by striking ''physician work effort'' and inserting ''value'';

(v) by striking subparagraph (E); and

(vi) by striking subparagraph (G);

(B) by striking paragraph (2) and inserting the following new paragraph:

''(2) COMPUTATION OF GEOGRAPHIC AND VALUE ADJUSTMENT FACTOR.—For purposes of subsection (b)(1)(C), for all physicians' services for each fee schedule area the Secretary shall establish a geographic and value adjustment factor equal to the sum of the geographic cost-of-practice adjustment factor (specified in paragraph (3)), the geographic malpractice adjustment factor (specified in paragraph (4)), and the value adjustment factor (specified in paragraph (5)) for the service and the area.''; and

(C) by striking paragraph (5) and inserting the following new paragraph:

''(5) PHYSICIAN WORK VALUE ADJUSTMENT FACTOR.—For purposes of paragraph (2), the 'physician work value adjustment factor' for a service for a fee schedule area, is the product of—

''(A) the proportion of the total relative value for the service that reflects the relative value units for the work component; and

''(B) the value index score for the area, based on the value index established under paragraph (6).''.

(c) AVAILABILITY OF QUALITY COMPONENT PRIOR TO IMPLEMENTATION.—The Secretary of Health and Human Services shall make the quality component described in section 1848(c)(6)(B) of the Social Security Act, as added by subsection (a), for each fee schedule area available to the public by not later than July 1, 2011.

(d) EFFECTIVE DATE.—Subject to subsection (e), the amendments made by this section shall apply to the Medicare physician fee schedule for 2012 and each subsequent year.

(e) TRANSITION.—Notwithstanding the amendments made by the preceding provisions of this section, the Secretary of Health and Human Services shall provide for an appropriate transition to the amendments made by this section. Under such transition, in the case of payments under such fee schedule for services furnished during—

(1) 2012, 25 percent of such payments shall be based on the amount of payment that would have applied to the services if such amendments had not been enacted and 75 percent of such payment shall be based on the amount of payment that would have applied to the services if such amendments had been fully implemented;

(2) 2013, 50 percent of such payment shall be based on the amount of payment that would have applied to the services if such amendments had not been enacted and 50 percent of such payment shall be based on the amount of payment that would have applied to the services if such amendments had been fully implemented; and

(3) 2014 and subsequent years, 100 percent of such payment shall be based on the amount of payment that is applicable under such amendments.

TITLE IV—LONG-TERM SERVICES PROVISIONS

SEC. 4001. SHORT TITLE.

This title may be cited as the ''Home and Community Balanced Incentives Act of 2009''.

Subtitle A—Balancing Incentives

SEC. 4101. ENHANCED FMAP FOR EXPANDING THE PROVISION OF NON-INSTITUTIONALLY-BASED LONG-TERM SERVICES AND SUPPORTS.

(a) ENHANCED FMAP TO ENCOURAGE EXPANSION.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in the first sentence of subsection (b)—

(A) by striking '', and (4)'' and inserting '', (4)''; and

(B) by inserting before the period the following: '', and (5) in the case of a balancing incentive payment State, as defined in subsection (y)(1), that meets the conditions described in subsection (y)(2), the Federal medical assistance percentage shall be increased by the applicable number of percentage points determined under subsection (y)(3) for the State with respect to medical assistance described in subsection (y)(4)''; and

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

''(y) STATE BALANCING INCENTIVE PAYMENTS PROGRAM.—For purposes of clause (5) of the first sentence of subsection (b):

''(1) BALANCING INCENTIVE PAYMENT STATE.—A balancing incentive payment State is a State—

''(A) in which less than 50 percent of the total expenditures for medical assistance for fiscal year 2009 for long-term services and supports (as defined by the Secretary, subject to paragraph (5)) are for non-institutionally-based long-term services and supports described in paragraph (5)(B);

''(B) that submits an application and meets the conditions described in paragraph (2); and

''(C) that is selected by the Secretary to participate in the State balancing incentive payment program established under this subsection.

''(2) CONDITIONS.—The conditions described in this paragraph are the following:

''(A) APPLICATION.—The State submits an application to the Secretary that includes the following:

''(i) A description of the availability of non-institutionally-based long-term services and supports described in paragraph (5)(B) available (for fiscal years beginning with fiscal year 2009).

''(ii) A description of eligibility requirements for receipt of such services.

''(iii) A projection of the number of additional individuals that the State expects to provide with such services to during the 5-fiscal year period that begins with fiscal year 2011.

''(iv) An assurance of the State's commitment to a consumer-directed long-term services and supports system that values quality of life in addition to quality of care and in which beneficiaries are empowered to choose providers and direct their own care as much as possible.

''(v) A proposed budget that details the State's plan to expand and diversify medical assistance for non-institutionally-based long-term services and supports described in paragraph (5)(B) during such 5-fiscal year period, and that includes—

''(I) a description of the new or expanded offerings of such services that the State will provide; and

''(II) the projected costs of the services identified in subclause (I).

''(vi) A description of how the State intends to achieve the target spending percentage applicable to the State under subparagraph (B).

''(vii) An assurance that the State will not use Federal funds, revenues described in section 1903(w)(1), or revenues obtained through the imposition of beneficiary cost-sharing for medical assistance for non-institutionally-based long-term services and supports described in paragraph (5)(B) for the non-federal share of expenditures for medical assistance described in paragraph (4).

''(B) TARGET SPENDING PERCENTAGES.—

''(i) In the case of a balancing incentive payment State in which less than 25 percent of the total expenditures for home and community-based services under the State plan and the various waiver authorities for fiscal year 2009 are for such services, the target spending percentage for the State to achieve by not later than October 1, 2015, is that 25 percent of the total expenditures for home and community-based services under the State plan and the various waiver authorities are for such services.

''(ii) In the case of any other balancing incentive payment State, the target spending percentage for the State to achieve by not later than October 1, 2015, is that 50 percent of the total expenditures for home and community-based services under the State plan and the various waiver authorities are for such services.

''(C) MAINTENANCE OF ELIGIBILITY REQUIREMENTS.—The State does not apply eligibility standards, methodologies, or procedures for determining eligibility for medical assistance for non-institutionally-based long-term services and supports described in paragraph (5)(B)) that are more restrictive than the eligibility standards, methodologies, or procedures in effect for such purposes on December 31, 2010.

''(D) USE OF ADDITIONAL FUNDS.—The State agrees to use the additional Federal funds paid to the State as a result of this subsection only for purposes of providing new or expanded offerings of non-institutionally-based long-term services and supports described in paragraph (5)(B) (including expansion through offering such services to increased numbers of beneficiaries of medical assistance under this title).

''(E) STRUCTURAL CHANGES.—The State agrees to make, not later than the end of the 6-month period that begins on the date the State submits and application under this paragraph, such changes to the administration of the State plan (and, if applicable, to waivers approved for the State that involve the provision of long-term care services and supports) as the Secretary determines, by regulation or otherwise, are essential to achieving an improved balance between the provision of non-institutionally-based long-term services and supports described in paragraph (5)(B) and other long-term services and supports, and which shall include the following:

''(i) 'NO WRONG DOOR'—SINGLE ENTRY POINT SYSTEM.—Development of a statewide system to enable consumers to access all long-term services and supports through an agency, organization, coordinated network, or portal, in accordance with such standards as the State shall establish and that—

''(I) shall require such agency, organization, network, or portal to provide—

''(aa) consumers with information regarding the availability of such services, how to apply for such services, and other referral services; and

''(bb) information regarding, and make recommendations for, providers of such services; and

''(II) may, at State option, permit such agency, organization, network, or portal to—

''(aa) determine financial and functional eligibility for such services and supports; and

''(bb) provide or refer eligible individuals to services and supports otherwise available in the community (under programs other than the State program under this title), such as housing, job training, and transportation.

''(ii) PRESUMPTIVE ELIGIBILITY.—At the option of the State, provision of a 60-day period of presumptive eligibility for medical assistance for non-institutionally-based long-term services and supports described in paragraph (5)(B) for any individual whom the State has reason to believe will qualify for such medical assistance (provided that any expenditures for such medical assistance during such period are disregarded for purposes of determining the rate of erroneous excess payments for medical assistance under section 1903(u)(1)(D)).

''(iii) CASE MANAGEMENT.—Development, in accordance with guidance from the Secretary, of conflict-free case management services to—

''(I) address transitioning from receipt of institutionally-based long-term services and supports described in paragraph (5)(A) to receipt of non-institutionally-based long-term services and supports described in paragraph (5)(B); and

''(II) in conjunction with the beneficiary, assess the beneficiary's needs and , if appropriate, the needs of family caregivers for the beneficiary, and develop a service plan, arrange for services and supports, support the beneficiary (and, if appropriate, the caregivers) in directing the provision of services and supports, for the beneficiary, and conduct ongoing monitoring to assure that services and supports are delivered to meet the beneficiary's needs and achieve intended outcomes.

''(iv) CORE STANDARDIZED ASSESSMENT INSTRUMENTS.—Development of core standardized assessment instruments for determining eligibility for non-institutionally-based long-term services and supports described in paragraph (5)(B), which shall be used in a uniform manner throughout the State, to—

''(I) assess a beneficiary's eligibility and functional level in terms of relevant areas that may include medical, cognitive, and behavioral status, as well as daily living skills, and vocational and communication skills;

''(II) based on the assessment conducted under subclause (I), determine a beneficiary's needs for training, support services, medical care, transportation, and other services, and develop an individual service plan to address such needs;

''(III) conduct ongoing monitoring based on the service plan; and

''(IV) require reporting of collect data for purposes of comparison among different service models.

''(F) DATA COLLECTION.—Collecting from providers of services and through such other means as the State determines appropriate the following data:

''(i) SERVICES DATA.—Services data from providers of non-institutionally-based long-term services and supports described in paragraph (5)(B) on a per-beneficiary basis and in accordance with such standardized coding procedures as the State shall establish in consultation with the Secretary.

''(ii) QUALITY DATA.—Quality data on a selected set of core quality measures agreed upon by the Secretary and the State that are linked to population-specific outcomes measures and accessible to providers.

''(iii) OUTCOMES MEASURES.—Outcomes measures data on a selected set of core population-specific outcomes measures agreed upon by the Secretary and the State that are accessible to providers and include—

''(I) measures of beneficiary and family caregiver experience with providers;

''(II) measures of beneficiary and family caregiver satisfaction with services; and

''(III) measures for achieving desired outcomes appropriate to a specific beneficiary, including employment, participation in community life, health stability, and prevention of loss in function.

''(3) APPLICABLE NUMBER OF PERCENTAGE POINTS INCREASE IN FMAP.—The applicable number of percentage points are—

''(A) in the case of a balancing incentive payment State subject to the target spending percentage described in paragraph (2)(B)(i), 5 percentage points; and

''(B) in the case of any other balancing incentive payment State, 2 percentage points.

''(4) ELIGIBLE MEDICAL ASSISTANCE EXPENDITURES.—

''(A) IN GENERAL.—Subject to subparagraph (B), medical assistance described in this paragraph is medical assistance for non-institutionally-based long-term services and supports described in paragraph (5)(B) that is provided during the period that begins on October 1, 2011, and ends on September 30, 2015.

''(B) LIMITATION ON PAYMENTS.—In no case may the aggregate amount of payments made by the Secretary to balancing incentive payment States under this subsection during the period described in subparagraph (A), or to a State to which paragraph (6) of the first sentence of subsection (b) applies, exceed $3,000,000,000.

''(5) LONG-TERM SERVICES AND SUPPORTS DEFINED.—In this subsection, the term 'long-term services and supports' has the meaning given that term by Secretary and shall include the following:

''(A) INSTITUTIONALLY-BASED LONG-TERM SERVICES AND SUPPORTS.—Services provided in an institution, including the following:

''(i) Nursing facility services.

''(ii) Services in an intermediate care facility for the mentally retarded described in subsection (a)(15).

''(B) NON-INSTITUTIONALLY-BASED LONG-TERM SERVICES AND SUPPORTS.—Services not provided in an institution, including the following:

''(i) Home and community-based services provided under subsection (c), (d), or (i), of section 1915 or under a waiver under section 1115.

''(ii) Home health care services.

''(iii) Personal care services.

''(iv) Services described in subsection (a)(26) (relating to PACE program services).

''(v) Self-directed personal assistance services described in section 1915(j)''.

(b) ENHANCED FMAP FOR CERTAIN STATES TO MAINTAIN THE PROVISION OF HOME AND COMMUNITY-BASED SERVICES.—The first sentence of section 1905(b) of such Act (42 U.S.C. 1396d(b)), as amended by subsection (a), is amended

(1) by striking '', and (5)'' and inserting '', (5)''; and

(2) by inserting before the period the following: '', and (6) in the case of a State in which at least 50 percent of the total expenditures for medical assistance for fiscal year 2009 for long-term services and supports (as defined by the Secretary for purposes of subsection (y)) are for non-institutionally-based long-term services and supports described in subsection (y)(5)(B), and which satisfies the requirements of subparagraphs (A) (other than clauses (iii), (v), and (vi)), (C), and (F) of subsection (y)(2), and has implemented the structural changes described in each clause of subparagraph (E) of that subsection, the Federal medical assistance percentage shall be increased by 1 percentage point with respect to medical assistance described in subparagraph (A) of subsection (y)(4) (but subject to the limitation described in subparagraph (B) of that subsection)''.

(c) GRANTS TO SUPPORT STRUCTURAL CHANGES.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall award grants to States for the following purposes:

(A) To support the development of common national set of coding methodologies and databases related to the provision of non-institutionally-based long-term services and supports described in paragraph (5)(B) of section 1905(y) of the Social Security Act (as added by subsection (a)).

(B) To make structural changes described in paragraph (2)(E) of section 1905(y) to the State Medicaid program.

(2) PRIORITY.—In awarding grants for the purpose described in paragraph (1)(A), the Secretary of Health and Human Services shall give priority to States in which at least 50 percent of the total expenditures for medical assistance under the State Medicaid program for fiscal year 2009 for long-term services and supports, as defined by the Secretary for purposes of section 1905(y) of the Social Security Act, are for non-institutionally-based long-term services and supports described in paragraph (5)(B) of such section.

(3) COLLABORATION.—States awarded a grant for the purpose described in paragraph (1)(A) shall collaborate with other States, the National Governor's Association, the National Conference of State Legislatures, the National Association of State Medicaid Directors, the National Association of State Directors of Developmental Disabilities, and other appropriate organizations in developing specifications for a common national set of coding methodologies and databases.

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for each of fiscal years 2010 through 2012.

(d) AUTHORITY FOR INDIVIDUALIZED BUDGETS UNDER WAIVERS TO PROVIDE HOME AND COMMUNITY-BASED SERVICES.—In the case of any waiver to provide home and community-based services under subsection (c) or (d) of section 1915 of the Social Security Act (42 U.S.C. 1396n) or section 1115 of such Act (42 U.S.C. 1315), that is approved or renewed after the date of enactment of this Act, the Secretary of Health and Human Services shall permit a State to establish individualized budgets that identify the dollar value of the services and supports to be provided to an individual under the waiver.

(e) OVERSIGHT AND ASSESSMENT.—

(1) DEVELOPMENT OF STANDARDIZED REPORTING REQUIREMENTS.—

(A) STANDARDIZATION OF DATA AND OUTCOME MEASURES.—The Secretary of Health and Human Services shall consult with States and the National Governor's Association, the National Conference of State Legislatures, the National Association of State Medicaid Directors, the National Association of State Directors of Developmental Disabilities, and other appropriate organizations to develop specifications for standardization of—

(i) reporting of assessment data for long-term services and supports (as defined by the Secretary for purposes of section 1905(y)(5) of the Social Security Act) for each population served, including information standardized for purposes of certified EHR technology (as defined in section 1903(t)(3)(A) of the Social Security Act (42 U.S.C. 1396b(t)(3)(A)) and under other electronic medical records initiatives; and

(ii) outcomes measures that track assessment processes for long-term services and supports (as so defined) for each such population that maintain and enhance individual function, independence, and stability.

(2) ADMINISTRATION OF HOME AND COMMUNITY SERVICES.—The Secretary of Health and Human Services shall promulgate regulations to ensure that all States develop service systems that are designed to—

(A) allocate resources for services in a manner that is responsive to the changing needs and choices of beneficiaries receiving non-institutionally-based long-term services and supports described in paragraph (5)(B) of section 1905(y) of the Social Security Act (as added by subsection (a)) (including such services and supports that are provided under programs other the State Medicaid program), and that provides strategies for beneficiaries receiving such services to maximize their independence;

(B) provide the support and coordination needed for a beneficiary in need of such services (and their family caregivers or representative, if applicable) to design an individualized, self-directed, community-supported life; and

(C) improve coordination among all providers of such services under federally and State-funded programs in order to—

(i) achieve a more consistent administration of policies and procedures across programs in relation to the provision of such services; and

(ii) oversee and monitor all service system functions to assure—

(I) coordination of, and effectiveness of, eligibility determinations and individual assessments; and

(II) development and service monitoring of a complaint system, a management system, a system to qualify and monitor providers, and systems for role-setting and individual budget determinations.

(3) MONITORING.—The Secretary of Health and Human Services shall assess on an ongoing basis and based on measures specified by the Agency for Healthcare Research and Quality, the safety and quality of non-institutionally-based long-term services and supports described in paragraph (5)(B) of section 1905(y) of that Act provided to beneficiaries of such services and supports and the outcomes with regard to such beneficiaries' experiences with such services. Such oversight shall include examination of—

(A) the consistency, or lack thereof, of such services in care plans as compared to those services that were actually delivered; and

(B) the length of time between when a beneficiary was assessed for such services, when the care plan was completed, and when the beneficiary started receiving such services.

(4) GAO STUDY AND REPORT.—The Comptroller General of the United States shall study the longitudinal costs of Medicaid beneficiaries receiving long-term services and supports (as defined by the Secretary for purposes of section 1905(y)(5) of the Social Security Act) over 5-year periods across various programs, including the non-institutionally-based long-term services and supports described in paragraph (5)(B) of such section, PACE program services under section 1894 of the Social Security Act (42 U.S.C. 1395eee, 1396u–4), and services provided under specialized MA plans for special needs individuals under part C of title XVIII of the Social Security Act.

Subtitle B—Strengthening the Medicaid Home and Community-Based State Plan Amendment Option

SEC. 4201. REMOVAL OF BARRIERS TO PROVIDING HOME AND COMMUNITY-BASED SERVICES UNDER STATE PLAN AMENDMENT OPTION FOR INDIVIDUALS IN NEED.

(a) PARITY WITH INCOME ELIGIBILITY STANDARD FOR INSTITUTIONALIZED INDIVIDUALS.—Paragraph (1) of section 1915(i) of the Social Security Act (42 U.S.C. 1396n(i)) is amended by striking ''150 percent of the poverty line (as defined in section 2110(c)(5))'' and inserting ''300 percent of the supplemental security income benefit rate established by section 1611(b)(1)''.

(b) ADDITIONAL STATE OPTIONS.—Section 1915(i) of the Social Security Act (42 U.S.C. 1396n(i)) is amended by adding at the end the following new paragraphs:

''(6) STATE OPTION TO PROVIDE HOME AND COMMUNITY-BASED SERVICES TO INDIVIDUALS ELIGIBLE FOR SERVICES UNDER A WAIVER.—

''(A) IN GENERAL.—A State that provides home and community-based services in accordance with this subsection to individuals who satisfy the needs-based criteria for the receipt of such services established under paragraph (1)(A) may, in addition to continuing to provide such services to such individuals, elect to provide home and community-based services in accordance with the requirements of this paragraph to individuals who are eligible for home and community-based services under a waiver approved for the State under subsection (c), (d), or (e) or under section 1115 to provide such services, but only for those individuals whose income does not exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1).

''(B) APPLICATION OF SAME REQUIREMENTS FOR INDIVIDUALS SATISFYING NEEDS-BASED CRITERIA.—Subject to subparagraph (C), a State shall provide home and community-based services to individuals under this paragraph in the same manner and subject to the same requirements as apply under the other paragraphs of this subsection to the provision of home and community-based services to individuals who satisfy the needs-based criteria established under paragraph (1)(A).

''(C) AUTHORITY TO OFFER DIFFERENT TYPE, AMOUNT, DURATION, OR SCOPE OF HOME AND COMMUNITY-BASED SERVICES.—A State may offer home and community-based services to individuals under this paragraph that differ in type, amount, duration, or scope from the home and community-based services offered for individuals who satisfy the needs-based criteria established under paragraph (1)(A), so long as such services are within the scope of services described in paragraph (4)(B) of subsection (c) for which the Secretary has the authority to approve a waiver and do not include room or board.

''(7) STATE OPTION TO OFFER HOME AND COMMUNITY-BASED SERVICES TO SPECIFIC, TARGETED POPULATIONS.—

''(A) IN GENERAL.—A State may elect in a State plan amendment under this subsection to target the provision of home and community-based services under this subsection to specific populations and to differ the type, amount, duration, or scope of such services to such specific populations.

''(B) 5-YEAR TERM.—

''(i) IN GENERAL.—An election by a State under this paragraph shall be for a period of 5 years.

''(ii) PHASE-IN OF SERVICES AND ELIGIBILITY PERMITTED DURING INITIAL 5-YEAR PERIOD.—A State making an election under this paragraph may, during the first 5-year period for which the election is made, phase-in the enrollment of eligible individuals, or the provision of services to such individuals, or both, so long as all eligible individuals in the State for such services are enrolled, and all such services are provided, before the end of the initial 5-year period.

''(C) RENEWAL.—An election by a State under this paragraph may be renewed for additional 5-year terms if the Secretary determines, prior to beginning of each such renewal period, that the State has—

''(i) adhered to the requirements of this subsection and paragraph in providing services under such an election; and

''(ii) met the State's objectives with respect to quality improvement and beneficiary outcomes.''.

(c) REMOVAL OF LIMITATION ON SCOPE OF SERVICES.—Paragraph (1) of section 1915(i) of the Social Security Act (42 U.S.C. 1396n(i)), as amended by subsection (a), is amended by striking ''or such other services requested by the State as the Secretary may approve''.

(d) OPTIONAL ELIGIBILITY CATEGORY TO PROVIDE FULL MEDICAID BENEFITS TO INDIVIDUALS RECEIVING HOME AND COMMUNITY-BASED SERVICES UNDER A STATE PLAN AMENDMENT.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(A) in subclause (XVIII), by striking ''or'' at the end;

(B) in subclause (XIX), by adding ''or'' at the end; and

(C) by inserting after subclause (XIX), the following new subclause:

''(XX) who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1915(i), or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection;''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)) is amended in the matter preceding subparagraph (A), by inserting ''1902(a)(10)(A)(ii)(XX),'' after ''1902(a)(10)(A)(ii)(XIX),''.

(B) Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended in the matter preceding paragraph (1)—

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

(ii) in clause (xiii), by adding ''or'' at the end; and

(iii) by inserting after clause (xiii) the following new clause:

''(xiv) individuals who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1915(i), or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection,''.

(e) ELIMINATION OF OPTION TO LIMIT NUMBER OF ELIGIBLE INDIVIDUALS OR LENGTH OF PERIOD FOR GRANDFATHERED INDIVIDUALS IF ELIGIBILITY CRITERIA IS MODIFIED.—Paragraph (1) of section 1915(i) of such Act (42 U.S.C. 1396n(i)) is amended—

(1) by striking subparagraph (C) and inserting the following:

''(C) PROJECTION OF NUMBER OF INDIVIDUALS TO BE PROVIDED HOME AND COMMUNITY-BASED SERVICES.—The State submits to the Secretary, in such form and manner, and upon such frequency as the Secretary shall specify, the projected number of individuals to be provided home and community-based services.''; and

(2) in subclause (II) of subparagraph (D)(ii), by striking ''to be eligible for such services for a period of at least 12 months beginning on the date the individual first received medical assistance for such services'' and inserting ''to continue to be eligible for such services after the effective date of the modification and until such time as the individual no longer meets the standard for receipt of such services under such pre-modified criteria''.

(f) ELIMINATION OF OPTION TO WAIVE STATEWIDENESS; ADDITION OF OPTION TO WAIVE COMPARABILITY.—Paragraph (3) of section 1915(i) of such Act (42 U.S.C. 1396n(3)) is amended by striking ''1902(a)(1) (relating to statewideness)'' and inserting ''1902(a)(10)(B) (relating to comparability)''.

(g) EFFECTIVE DATE.—The amendments made by this section take effect on the first day of the first fiscal year quarter that begins after the date of enactment of this Act.

SEC. 4202. MANDATORY APPLICATION OF SPOUSAL IMPOVERISHMENT PROTECTIONS TO RECIPIENTS OF HOME AND COMMUNITY-BASED SERVICES.

(a) IN GENERAL.—Section 1924(h)(1)(A) of the Social Security Act (42 U.S.C. 1396r–5(h)(1)(A)) is amended by striking ''(at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI)'' and inserting ''is eligible for medical assistance for home and community-based services under subsection (c), (d), (e), or (i) of section 1915''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on October 1, 2009.

SEC. 4203. STATE AUTHORITY TO ELECT TO EXCLUDE UP TO 6 MONTHS OF AVERAGE COST OF NURSING FACILITY SERVICES FROM ASSETS OR RESOURCES FOR PURPOSES OF ELIGIBILITY FOR HOME AND COMMUNITY-BASED SERVICES.

(a) IN GENERAL.—Section 1917 of the Social Security Act (42 U.S.C. 1396p) is amended by adding at the end the following new subsection:

''(i) STATE AUTHORITY TO EXCLUDE UP TO 6 MONTHS OF AVERAGE COST OF NURSING FACILITY SERVICES FROM HOME AND COMMUNITY-BASED SERVICES ELIGIBILITY DETERMINATIONS.—Nothing in this section or any other provision of this title, shall be construed as prohibiting a State from excluding from any determination of an individual's assets or resources for purposes of determining the eligibility of the individual for medical assistance for home and community-based services under subsection (c), (d), (e), or (i) of section 1915 (if a State imposes an limitation on assets or resources for purposes of eligibility for such services), an amount equal to the product of the amount applicable under subsection (c)(1)(E)(ii)(II) (at the time such determination is made) and such number, not to exceed 6, as the State may elect.''.

(b) RULE OF CONSTRUCTION.—Nothing in the amendment made by subsection (a) shall be construed as affecting a State's option to apply less restrictive methodologies under section 1902(r)(2) for purposes of determining income and resource eligibility for individuals specified in that section.

Subtitle C—Coordination of Home and Community-Based Waivers

SEC. 4301. STREAMLINED PROCESS FOR COMBINED WAIVERS UNDER SUBSECTIONS (B) AND (C) OF SECTION 1915 .

Not later than 90 days after the date of enactment of this Act, the Secretary of Health and Human Services shall create a template to streamline the process of approving, monitoring, evaluating, and renewing State proposals to conduct a program that combines the waiver authority provided under subsections (b) and (c) of section 1915 of the Social Security Act (42 U.S.C. 1396n) into a single program under which the State provides home and community-based services to individuals based on individualized assessments and care plans (in this section referred to as the ''combined waivers program''). The template required under this section shall provide for the following:

(1) A standard 5-year term for conducting a combined waivers program.

(2) Harmonization of any requirements under subsections (b) and (c) of such section that overlap.

(3) An option for States to elect, during the first 5-year term for which the combined waivers program is approved to phase-in the enrollment of eligible individuals, or the provision of services to such individuals, or both, so long as all eligible individuals in the State for such services are enrolled, and all such services are provided, before the end of the initial 5-year period.

(4) Examination by the Secretary, prior to each renewal of a combined waivers program, of how well the State has—

(A) adhered to the combined waivers program requirements; and

(B) performed in meeting the State's objectives for the combined waivers program, including with respect to quality improvement and beneficiary outcomes.

TITLE V—HOME AND COMMUNITY-BASED SERVICES PROVISIONS

SEC. 5001. SHORT TITLE.

This Act may be cited as the ''Project 2020: Building on the Promise of Home and Community-Based Services Act of 2009''.

SEC. 5002. LONG-TERM SERVICES AND SUPPORTS.

The Social Security Act (42 U.S.C. 301 et seq.) is amended by adding at the end the following:

''TITLE XXII—LONG-TERM SERVICES AND SUPPORTS

''SEC. 2201. DEFINITIONS.

''Except as otherwise provided, the terms used in this title have the meanings given the terms in section 102 of the Older Americans Act of 1965 (42 U.S.C. 3002).

''Subtitle A—Single-Entry Point System Program

''SEC. 2211. STATE SINGLE-ENTRY POINT SYSTEMS.

''(a) DEFINITIONS.—In this title:

''(1) LONG-TERM SERVICES AND SUPPORTS.—The term 'long-term services and supports' means any service (including a disease prevention and health promotion service, an in-home service, or a case management service), care, or item (including an assistive device) that is—

''(A) intended to assist individuals in coping with, and, to the extent practicable, compensating for, functional impairment in carrying out activities of daily living;

''(B) furnished at home, in a community care setting, including a small community care setting (as defined in section 1929(g)(1)) and a large community care setting (as defined in section 1929(h)(1)), or in a long-term care facility; and

''(C) not furnished to diagnose, treat, or cure a medical disease or condition.

''(2) SINGLE-ENTRY POINT SYSTEM.—The term 'single-entry point system' means any coordinated system for providing—

''(A) comprehensive information to consumers and caregivers on the full range of available public and private long-term services and supports, options, service providers, and resources, including information on the availability of integrated long-term care, including consumer directed care options;

''(B) personal counseling to assist individuals in assessing their existing or anticipated long-term care needs, and developing and implementing a plan for long-term care designed to meet their specific needs and circumstances; and

''(C) consumers and caregivers access to the range of publicly supported and privately supported long-term services and supports that are available.

''(b) PROGRAM.—The Secretary shall establish and carry out a single-entry point system program. In carrying out the program, the Secretary shall make grants to States, from allotments described in subsection (c), to pay for the Federal share of the cost of establishing State single-entry point systems.

''(c) ALLOTMENTS.—

''(1) ALLOTMENTS TO INDIAN TRIBES AND TERRITORIES.—

''(A) RESERVATION.—The Secretary shall reserve from the funds made available under subsection (g)—

''(i) for fiscal year 2010, $1,962,456; and

''(ii) for each subsequent fiscal year, $1,962,456, increased by the percentage increase in the Consumer Price Index for All Urban Consumers, between October of the fiscal year preceding the subsequent fiscal year and October, 2007.

''(B) ALLOTMENTS.—The Secretary shall use the funds reserved under subparagraph (A) to make allotments to—

''(i) Indian tribes; and

''(ii) Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Commonwealth of Puerto Rico, and the United States Virgin Islands.

''(2) ALLOTMENTS TO STATES.—

''(A) IN GENERAL.—

''(i) AMOUNT.—The Secretary shall allot to each eligible State for a fiscal year the sum of the fixed amount determined under subparagraph (B), and the allocation determined under subparagraph (C), for the State.

''(ii) SUBGRANTS TO AREA AGENCIES ON AGING.—

''(I) IN GENERAL.—Each State agency receiving an allotment under clause (i) shall use such allotment to make subgrants to area agencies on aging that can demonstrate performance capacity to carry out activities described in this section whether such area agency on aging carries out the activities directly or through contract with an aging network or disability entity.

''(II) SUBGRANTS TO OTHER ENTITIES.—A State agency may make subgrants described in subclause (I) to other qualified aging network or disability entities only if the area agency on aging chooses not to apply for a subgrant or is not able to demonstrate performance capacity to carry out the activities described in this section.

''(III) SUBGRANTEE RECIPIENT SUBGRANTS.—An administrator of a single-entry point system established by a State receiving an allotment under clause (i) shall make any necessary subgrants to key partners involved in developing, planning, or implementing the single-entry point system. Such partners may include centers for independent living (as defined in section 702 of the Rehabilitation Act of 1973 (29 U.S.C. 796a)).

''(B) FIXED AMOUNTS FOR STATES.—

''(i) RESERVATION.—The Secretary shall reserve from the funds made available under subsection (g)—

''(I) for fiscal year 2010, $15,759,000; and

''(II) for each subsequent fiscal year, $15,759,000, increased by the percentage increase in the Consumer Price Index for All Urban Consumers, between October of the fiscal year preceding the subsequent fiscal year and October, 2007.

''(ii) FIXED AMOUNTS.—The Secretary shall use the funds reserved under clause (i) to provide equal fixed amounts to the States.

''(C) ALLOCATION FOR STATES.—The Secretary shall allocate to each eligible State for a fiscal year an amount that bears the same relationship to the funds made available under subsection (g) (and not reserved under paragraph (1) or subparagraph (B)) for that fiscal year as the number of persons who are either older individuals or individuals with disabilities in that State bears to the number of such persons or individuals in all the States.

''(D) DETERMINATION OF NUMBER OF PERSONS.—

''(i) OLDER INDIVIDUALS.—The number of older individuals in any State and in all States shall be determined by the Secretary on the basis of the most recent data available from the Bureau of the Census, and other reliable demographic data satisfactory to the Secretary.

''(ii) INDIVIDUALS WITH DISABILITIES.—The number of individuals with disabilities in any State and in all States shall be determined by the Secretary on the basis of the most recent data available from the American Community Survey, and other reliable demographic data satisfactory to the Secretary, on individuals who have a sensory disability, physical disability, mental disability, self-care disability, go-outside-home disability, or employment disability.

''(3) ELIGIBILITY.—In addition to the States determined by the Secretary to be eligible for a grant under this section, a State that receives a Federal grant for an aging and disability resource center is eligible for a grant under this section.

''(4) DEFINITION.—In this subsection, the term 'State' shall not include any jurisdiction described in paragraph (1)(B)(ii).

''(d) APPLICATIONS.—

''(1) IN GENERAL.—To be eligible to receive an initial grant under this section, a State agency shall, after consulting and coordinating with consumers, other stakeholders, and area agencies on aging in the State, if any, submit an application to the Secretary at such time, in such manner, and containing the following information:

''(A) Evidence of substantial involvement of stakeholders and agencies in the State that are administering programs that will be the subject of referrals.

''(B) The applicant shall establish or designate a collaborative board to ensure meaningful involvement of stakeholders in the development, planning, implementation, and evaluation of a single-entry point system consistent with the following:

''(i) The collaborative board shall be composed of—

''(I) individuals representing all populations served by the applicant's single-entry point system, including older adults and individuals from diverse backgrounds who have a disability or a chronic condition requiring long-term support;

''(II) a representative from the local center for independent living (as defined in section 702 of the Rehabilitation Act of 1973 (29 U.S.C. 796a)), and representatives from other organizations that provide services to the individuals served by the system and those who advocate on behalf of such individuals; and

''(III) representatives of the government and non-governmental agencies that are affected by the system.

''(ii) The applicant shall work in conjunction with the collaborative board on—

''(I) the design and operations of the single-entry point system;

''(II) stakeholder input; and

''(III) other program and policy development issues related to the single-entry point system.

''(iii) An advisory board established under the Real Choice Systems Change Program or for an existing single-entry point system may be used to carry out the activities of a collaborative board under this subparagraph if such advisory board meets the requirements under clause (i).

''(C) The applicant's plan for providing—

''(i) comprehensive information on the full range of available public and private long-term services and supports options, providers, and resources, including building awareness of the single-entry point system as a resource;

''(ii) objective, neutral, and personal information, counseling, and assistance to individuals and their caregivers in assessing their existing or anticipated long-term care needs, and developing and implementing a plan for long-term care to meet their needs;

''(iii) for eligibility screening and referral for services;

''(iv) for stakeholder input;

''(v) for a management information system; and

''(vi) for an evaluation of the effectiveness of the single-entry point system.

''(D) A specification of the period of the grant request, which shall include not less than 3 consecutive fiscal years in the 5-fiscal-year-period beginning with fiscal year 2010.

''(E) Such other information as the Secretary determines appropriate.

''(2) APPLICATION FOR CONTINUATION.—

''(A) IN GENERAL.—A State that receives an initial grant under this section shall apply, after consulting and coordinating with the area agencies on aging, for a continuation of the initial grant, which includes a description of any significant changes to the information provided in the initial application and such data concerning performance measures related to the requirements in the initial application as the Secretary shall require.

''(B) EFFECT.—The requirement under subparagraph (A) shall be in effect through fiscal year 2020.

''(e) USE OF FUNDS.—

''(1) IN GENERAL.—A State that receives a grant under this section shall use the funds made available through the grant to—

''(A) establish a State single-entry point system, to enable older individuals and individuals with disabilities and their caregivers to obtain resources concerning long-term services and supports options; and

''(B) provide information on, access to, and assistance regarding long-term services and supports.

''(2) SERVICES.—In particular, the State single-entry point system shall be the referral source to—

''(A) provide information about long-term care planning and available long-term services and supports through a variety of media (such as websites, seminars, and pamphlets);

''(B) provide assistance with making decisions about long-term services and supports and determining the most appropriate services through options counseling, future financial planning, and case management;

''(C) provide streamlined access to and assistance with applying for federally funded long-term care benefits (including medical assistance under title XIX, Medicare skilled nursing facility services, services under title III of the Older Americans Act of 1965 (42 U.S.C. 3021 et seq.), the services of Aging and Disability Resource Centers), and State-funded and privately funded long-term care benefits, through efforts to shorten and simplify the eligibility processes for older individuals and individuals with disabilities;

''(D) provide referrals to the State evidence-based disease prevention and health promotion programs under subtitle B;

''(E) allocate the State funds available under subtitle C and carry out the State enhanced nursing home diversion program under subtitle C; and

''(F) and provide information about, other services available in the State that may assist an individual to remain in the community, including the Medicare and Medicaid programs, the State health insurance assistance program, the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.), and the Low-Income Home Energy Assistance Program under the Low-Income Home Energy Assistance Act of 1981 (42 U.S.C. 8621 et seq.), and such other services, as the State shall include.

''(3) COLLABORATIVE ARRANGEMENTS.—

''(A) CENTER FOR INDEPENDENT LIVING.—Each entity receiving an allotment under subsection (c) shall involve in the planning and implementation of the single-entry point system the local center for independent living (as defined in section 702 of the Rehabilitation Act of 1973 (29 U.S.C. 796a)), which provides information, referral, assistance, or services to individuals with disabilities.

''(B) OTHER ENTITIES.—To the extent practicable, the State single-entry point system is encouraged to enter into collaborative arrangements with aging and disability programs, service providers, agencies, the direct care work force, and other entities in order to ensure that information about such services may be made available to individuals accessing the State single-entry point system.

''(f) FEDERAL SHARE.—

''(1) IN GENERAL.—The Federal share of the cost described in subsection (b) shall be 75 percent.

''(2) NON-FEDERAL SHARE.—The State may provide the non-Federal share of the cost in cash or in-kind, fairly evaluated, including plant, equipment, or services. The State may provide the non-Federal share from State, local, or private sources.

''(g) FUNDING.—

''(1) IN GENERAL.—The Secretary shall use amounts made available under paragraph (2) to make the grants described in subsection (b).

''(2) FUNDING.—There are authorized to be appropriated to carry out this section—

''(A) $30,900,000 for fiscal year 2010;
''(B) $38,264,000 for fiscal year 2011;
''(C) $48,410,000 for fiscal year 2012;
''(D) $53,560,000 for fiscal year 2013;
''(E) $63,860,000 for fiscal year 2014;
''(F) $69,010,000 for fiscal year 2015;
''(G) $74,160,000 for fiscal year 2016;
''(H) $79,310,000 for fiscal year 2017;
''(I) $84,460,000 for fiscal year 2018;
''(J) $89,610,000 for fiscal year 2019; and
''(K) $95,790,000 for fiscal year 2020.

''(3) AVAILABILITY.—Funds appropriated under paragraph (2) shall remain available until expended.

''Subtitle B—Healthy Living Program

''SEC. 2221. EVIDENCE-BASED DISEASE PREVENTION AND HEALTH PROMOTION PROGRAMS.

''(a) PROGRAM.—The Secretary shall establish and carry out a healthy living program. In carrying out the program, the Secretary shall make grants to State agencies, from allotments described in subsection (b), to pay for the Federal share of the cost of carrying out evidence-based disease prevention and health promotion programs.

''(b) ALLOTMENTS.—

''(1) ALLOTMENTS TO INDIAN TRIBES AND TERRITORIES.—

''(A) RESERVATION.—The Secretary shall reserve from the funds made available under subsection (g)—

''(i) for fiscal year 2010, $1,500,952; and

''(ii) for each subsequent fiscal year, $1,500,952, increased by the percentage increase in the Consumer Price Index for All Urban Consumers, between October of the fiscal year preceding the subsequent fiscal year and October, 2007.

''(B) ALLOTMENTS.—The Secretary shall use the reserved funds under subparagraph (A) to make allotments to—

''(i) Indian tribes; and

''(ii) Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Commonwealth of Puerto Rico, and the United States Virgin Islands.

''(2) IN GENERAL.—

''(A) AMOUNTS.—

''(i) IN GENERAL.—Except as provided in paragraph (3), the Secretary shall allot to each eligible State for a fiscal year an amount that bears the same relationship to the funds made available under this section and not reserved under paragraph (1) for that fiscal year as the number of older individuals in the State bears to the number of older individuals in all the States.

''(ii) OLDER INDIVIDUALS.—The number of older individuals in any State and in all States shall be determined by the Secretary on the basis of the most recent data available from the Bureau of the Census, and other reliable demographic data satisfactory to the Secretary.

''(B) SUBGRANTS.—

''(i) IN GENERAL.—Each State agency that receives an amount under subparagraph (A) shall award subgrants to area agencies on aging that can demonstrate performance capacity to carry out activities under this section whether such area agency on aging carries out the activities directly or through contract with an aging network entity.

''(ii) SUBGRANTS TO OTHER ENTITIES.—A State agency may make subgrants described in clause (i) to other qualified aging network entities only if the area agency on aging chooses not to apply for a subgrant or is not able to demonstrate performance capacity to carry out the activities described in this section.

''(3) MINIMUM ALLOTMENT.—No State shall receive an allotment under this section for a fiscal year that is less than 0.5 percent of the funds made available to carry out this section for that fiscal year and not reserved under paragraph (1).

''(4) ELIGIBILITY.—In addition to the States determined by the Secretary to be eligible for a grant under this section, a State that receives a Federal grant for evidence-based disease prevention is eligible for a grant under this section.

''(c) APPLICATIONS.—To be eligible to receive a grant under this section, a State agency shall, after consulting and coordinating with consumers, other stakeholders, and area agencies on aging in the State, if any, submit an application to the Secretary at such time, in such manner, and containing the following information:

''(1) A description of the evidence-based disease prevention and health promotion program.

''(2) Sufficient information to demonstrate that the infrastructure exists to support the program.

''(3) A specification of the period of the grant request, which shall include not less than 3 consecutive fiscal years in the 5 fiscal year period beginning with fiscal year 2010.

''(4) Such other information as the Secretary determines appropriate.

''(d) APPLICATION FOR CONTINUATION.—

''(1) IN GENERAL.—A State that receives an initial grant under this section shall apply, after consulting and coordinating with the area agencies on aging, for a continuation of the initial grant, which application shall include—

''(A) a description of any significant changes to the information provided in the initial application; and

''(B) such data concerning performance measures related to the requirements in the initial application as the Secretary shall require.

''(2) EFFECT.—The requirement under paragraph (1) shall be in effect through fiscal year 2020.

''(e) USE OF FUNDS.—A State that receives a grant under this section shall use the funds made available through the grant to carry out—

''(1) an evidence-based chronic disease self-management program;

''(2) an evidence-based falls prevention program; or

''(3) another evidence-based disease prevention and health promotion program.

''(f) FEDERAL SHARE.—

''(1) IN GENERAL.—The Federal share of the cost described in subsection (a) shall be 85 percent.

''(2) NON-FEDERAL SHARE.—The State may provide the non-Federal share of the cost in cash or in-kind, fairly evaluated, including

plant, equipment, or services. The State may provide the non-Federal share from State, local, or private sources.

''(g) FUNDING.—

''(1) IN GENERAL.—The Secretary shall use amounts made available under paragraph (2) to make the grants described in subsection (a).

''(2) FUNDING.—There are authorized to be appropriated to carry out this section—

''(A) $36,050,000 for fiscal year 2010;
''(B) $41,200,000 for fiscal year 2011;
''(C) $56,650,000 for fiscal year 2012;
''(D) $77,250,000 for fiscal year 2013;
''(E) $92,700,000 for fiscal year 2014;
''(F) $103,000,000 for fiscal year 2015;
''(G) $118,450,000 for fiscal year 2016;
''(H) $133,900,000 for fiscal year 2017;
''(I) $149,350,000 for fiscal year 2018;
''(J) $157,590,000 for fiscal year 2019; and
''(K) $173,040,000 for fiscal year 2020.

''(3) AVAILABILITY.—Funds appropriated under paragraph (2) shall remain available until expended.

''Subtitle C—Diversion Programs

''SEC. 2231. ENHANCED NURSING HOME DIVERSION PROGRAMS.

''(a) DEFINITION.—In this section:

''(1) LOW-INCOME SENIOR.—The term 'low-income senior' means an individual who—

''(A) is age 75 or older; and

''(B) is from a household with a household income that is not less than 150 percent, and not more than 300 percent, of the poverty line.

''(2) NURSING HOME.—The term 'nursing home' means—

''(A) a skilled nursing facility, as defined in section 1819(a); or

''(B) a nursing facility, as defined in section 1919(a).

''(b) PROGRAM.—

''(1) IN GENERAL.—The Secretary shall establish and carry out a diversion program. In carrying out the program, the Secretary shall make grants to States, from allotments described in subsection (c), to pay for the Federal share of the cost of carrying out enhanced nursing home diversion programs.

''(2) COHORTS.—The Secretary shall make the grants to—

''(A) a first year cohort consisting of one third of the States, for fiscal year 2010;

''(B) a second year cohort consisting of the cohort described in subparagraph (A) and an additional one third of the States, for fiscal year 2011; and

''(C) a third year cohort consisting of all the eligible States, for fiscal year 2012 and each subsequent fiscal year.

''(3) READINESS.—In determining whether to include an eligible State in the first year, second year, or third year and subsequent year cohort, the Secretary shall consider the readiness of the State to carry out an enhanced nursing home diversion program under this section. Readiness shall be determined based on a consideration of the following factors:

''(A) Availability of a comprehensive array of home- and community-based services.

''(B) Sufficient home- and community-based services provider capacity.

''(C) Availability of housing.

''(D) Availability of supports for consumer-directed services, including whether a fiscal intermediary is in place.

''(E) Ability to perform timely eligibility determinations and assessment for services.

''(F) Existence of a quality assessment and improvement program for home and community-based services.

''(G) Such other factors as the Secretary determines appropriate.

''(c) ALLOTMENTS.—

''(1) IN GENERAL.—

''(A) AMOUNT.—The Secretary shall allot to an eligible State (within the applicable cohort) for a fiscal year an amount that bears the same relationship to the funds made available under subsection (i) for that fiscal year as the number of low-income seniors in the State bears to the number of low-income seniors within States in the applicable cohort for that fiscal year.

''(B) LOW-INCOME SENIORS.—The number of low-income seniors in any State and in all States shall be determined by the Secretary on the basis of the most recent data available from the American Community Survey, and other reliable demographic data satisfactory to the Secretary.

''(2) ELIGIBILITY.—In addition to the States determined by the Secretary to be eligible for a grant under this section, a State that receives a Federal grant for a nursing home diversion is eligible for a grant under this section.

''(d) APPLICATIONS.—To be eligible to receive a grant under this section, a State agency shall, after consulting and coordinating with consumers, other stakeholders, and area agencies on aging in the State, if any, submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a specification of the period of the grant request, which shall include not less than 3 consecutive fiscal years in the 5 fiscal year period beginning with the fiscal year prior to the year of application.

''(e) APPLICATION FOR CONTINUATION.—

''(1) IN GENERAL.—A State that receives an initial grant under this section shall apply, after consulting and coordinating with the area agencies on aging, for a continuation of the initial grant, which application shall include—

''(A) a description of any significant changes to the information provided in the initial application; and

''(B) such data concerning performance measures related to the requirements in the initial application as the Secretary shall require.

''(2) EFFECT.—The requirement under paragraph (1) shall be in effect through fiscal year 2020.

''(f) USE OF FUNDS.—

''(1) IN GENERAL.—A State that receives a grant under this section shall carry out the following:

''(A) Use the funds made available through the grant to carry out an enhanced nursing home diversion program that enables eligible individuals to avoid admission into nursing homes by enabling the individuals to obtain alternative long-term services and supports and remain in their communities.

''(B) Award subgrants to area agencies on aging that can demonstrate performance capacity to carry out activities under this section whether such area agency on aging carries out the activities directly or through contract with an aging network entity. A State may make subgrants to other qualified aging network entities only if the area agency on aging chooses not to apply for a subgrant or is not able to demonstrate performance capacity to carry out the activities described in this section.

''(2) CASE MANAGEMENT.—

''(A) IN GENERAL.—The State, through the State single-entry point system established under subtitle A, shall provide for case management services to the eligible individuals.

''(B) USE OF EXISTING SERVICES.—In carrying out subparagraph (A), the State agency or area agency on aging may utilize existing case management services delivery networks if—

''(i) the networks have adequate safeguards against potential conflicts of interest; and

''(ii) the State agency or area agency on aging includes a description of such safeguards in the grant application.

''(C) CARE PLAN.—The State shall provide for development of a care plan for each eligible individual served, in consultation with the eligible individual and their caregiver, as appropriate. In developing the care plan, the State shall explain the option of consumer directed care and assist an individual, who so requests, with developing a consumer-directed care plan that shall include arranging for support services and funding. Such assistance shall include providing information and outreach to individuals in the hospital, in a nursing home for post-acute care, or undergoing changes in their health status or caregiver situation.

''(g) ELIGIBLE INDIVIDUALS.—In this section, the term 'eligible individual' means an individual—

''(1) who has been determined by the State to be at high functional risk of nursing home placement, as defined by the State agency in the State agency's grant application;

''(2) who is not eligible for medical assistance under title XIX; and

''(3) who meets the income and asset eligibility requirements established by the State and included in such State's grant application for approval by the Secretary.

''(h) FEDERAL SHARE.—

''(1) IN GENERAL.—The Federal share of the cost described in subsection (b) shall be, for a State and for a fiscal year, the sum of—

''(A) the Federal medical assistance percentage applicable to the State for the year under section 1905(b); and

''(B) 5 percentage points.

''(2) NON-FEDERAL SHARE.—The State may provide the non-Federal share of the cost in cash or in-kind, fairly evaluated, including plant, equipment, or services. The State may provide the non-Federal share from State, local, or private sources.

''(i) FUNDING.—

''(1) IN GENERAL.—The Secretary shall use amounts made available under paragraph (2) to make the grants described in subsection (b).

''(2) FUNDING.—There are authorized to be appropriated to carry out this section—

''(A) $111,825,137 for fiscal year 2010;
''(B) $337,525,753 for fiscal year 2011;
''(C) $650,098,349 for fiscal year 2012;
''(D) $865,801,631 for fiscal year 2013;
''(E) $988,504,887 for fiscal year 2014;
''(F) $1,124,547,250 for fiscal year 2015;
''(G) $1,276,750,865 for fiscal year 2016;
''(H) $1,364,488,901 for fiscal year 2017;
''(I) $1,466,769,052 for fiscal year 2018;
''(J) $1,712,755,702 for fiscal year 2019; and
''(K) $1,712,755,702 for fiscal year 2020.

''(3) AVAILABILITY.—Funds appropriated under paragraph (2) shall remain available until expended.

''Subtitle D—Administration, Evaluation, and Technical Assistance

''SEC. 2241. ADMINISTRATION, EVALUATION, AND TECHNICAL ASSISTANCE.

''(a) ADMINISTRATION AND EXPENSES.—For purposes of carrying out this title, there are authorized to be appropriated for administration and expenses—

''(1) of the area agencies on aging—

''(A) $16,825,895 for fiscal year 2010;
''(B) $39,246,141 for fiscal year 2011;
''(C) $50,766,948 for fiscal year 2012;
''(D) $66,999,101 for fiscal year 2013;
''(E) $76,979,152 for fiscal year 2014;
''(F) $87,163,513 for fiscal year 2015;
''(G) $98,780,562 for fiscal year 2016;
''(H) $106,063,792 for fiscal year 2017;
''(I) $114,324,642 for fiscal year 2018;
''(J) $123,312,948 for fiscal year 2019; and
''(K) $133,215,845 for fiscal year 2020;

''(2) of the State agencies—

''(A) $8,412,948 for fiscal year 2010;
''(B) $19,623,071 for fiscal year 2011;
''(C) $25,383,474 for fiscal year 2012;

''(D) $33,499,551 for fiscal year 2013;
''(E) $38,489,576 for fiscal year 2014;
''(F) $43,581,756 for fiscal year 2015;
''(G) $49,390,281 for fiscal year 2016;
''(H) $53,031,896 for fiscal year 2017;
''(I) $57,162,321 for fiscal year 2018;
''(J) $61,656,474 for fiscal year 2019; and
''(K) $66,607,923 for fiscal year 2020; and
''(3) of the Administration—
''(A) $2,103,237 for fiscal year 2010;
''(B) $4,905,768 for fiscal year 2011;
''(C) $6,345,868 for fiscal year 2012;
''(D) $8,374,888 for fiscal year 2013;
''(E) $9,622,394 for fiscal year 2014;
''(F) $10,895,439 for fiscal year 2015;
''(G) $12,347,570 for fiscal year 2016;
''(H) $13,257,974 for fiscal year 2017;
''(I) $14,290,580 for fiscal year 2018;
''(J) $15,414,118 for fiscal year 2019; and
''(K) $16,651,981 for fiscal year 2020.

''(b) EVALUATION AND TECHNICAL ASSISTANCE.—

''(1) CONDITIONS TO RECEIPT OF GRANT.—In awarding grants under this title, the Secretary shall condition receipt of the grant for the second and subsequent grant years on a satisfactory determination that the State agency is meeting benchmarks specified in the grant agreement for each grant awarded under this title.

''(2) EVALUATIONS.—The Secretary shall measure and evaluate, either directly or through grants or contracts, the impact of the programs authorized under this title. Not later than June 1 of the year that is 6 years after the year of the date of enactment of the Project 2020: Building on the Promise of Home and Community-Based Services Act of 2009 and every 2 years thereafter, the Secretary shall—

''(A) compile the reports of the measures and evaluations of the grantees;

''(B) establish benchmarks to show progress toward savings; and

''(C) present a compilation of the information under this paragraph to Congress.

''(3) TECHNICAL ASSISTANCE GRANTS.—The Secretary shall award technical assistance grants, including State specific grants whenever practicable, to carry out the programs authorized under this title.

''(4) TRANSFER.—There are authorized to be appropriated for such evaluation and technical assistance under this subsection—

''(A) $4,206,474 for fiscal year 2010;
''(B) $9,811,535 for fiscal year 2011;
''(C) $8,461,158 for fiscal year 2012;
''(D) $11,166,517 for fiscal year 2013;
''(E) $12,829,859 for fiscal year 2014;
''(F) $14,527,252 for fiscal year 2015;
''(G) $16,463,427 for fiscal year 2016;
''(H) $17,677,299 for fiscal year 2017;
''(I) $19,054,107 for fiscal year 2018;
''(J) $20,552,158 for fiscal year 2019; and
''(K) $22,202,641 for fiscal year 2020.

''(c) AVAILABILITY.—Funds appropriated under this section shall remain available until expended.''.

By Mr. UDALL, of Colorado (for himself and Mr. BENNET:)

S. 1264. A bill to require the Secretary of the Interior to assess the irrigation infrastructure of the Pine River Indian Irrigation Project in the State of Colorado and provide grants to, and enter into cooperative agreements with, the Southern Ute Indian Tribe to assess, repair, rehabilitate, or reconstruct existing infrastructure, and for other purposes; to the Committee on Indian Affairs.

Mr. UDALL of Colorado. Mr. President, today I rise to discuss a bill that I introduced, which seeks to rehabilitate an important irrigation and flood control system that is vital to serving the agricultural and flood protection needs in Southwestern Colorado.

More than 100 years ago, both Indian and non-Indian communities utilized the water from the Los Pinos or Pine River to irrigate areas of Southwest Colorado. As the population and local agriculture grew, so did the need for more advanced infrastructure. In 1936, the Pine River Indian Irrigation Project was authorized by Congress in the Department of Interior Appropriation Act, and in 1937 the project grew the system's capacity to provide water for over 63,000 acres of land. The development of this project provided much needed protection for crops and communities from spring floods and summer drought.

Today, similar forces of population growth and a steady demand for irrigated water are exacerbated by aging and deteriorating infrastructure, creating a need for a stronger system. The Government Accountability Office has found the deterioration of key project facilities to be severe. As deferred maintenance and upkeep mount, there is a growing threat to water conservation efforts, a reliable water supply, growth in agricultural production, economic sustainability, a safe community, and, equally important, the preservation of culture and livelihood of the Southern Ute Indian Tribe. Though the Southern Ute Tribe and others who live along the Pine River understand the hazards presented by aging infrastructure, more needs to be done to comprehend the full extent of these hazards.

Tribal members, who would like to bring idle lands back into agricultural production and continue as good stewards of the land, cannot be sure if much-needed water will get to their lands as a result of failed structures, overdue maintenance, and inadequate funding. Now, the estimated costs to rehabilitate the system far exceed the ability of water users to pay for improvements while managing profitable operations.

The Pine River Indian Irrigation Project Act of 2009 would fix decades of neglect and inadequate funding for the Pine River Indian Irrigation Project. This legislation would direct the Secretary of the Interior, acting through the Commissioner of Reclamation, to fully assess the needs of the Pine River Indian Irrigation Project. It would also grant the authority to the Secretary of the Interior to provide grants to, and enter into cooperative agreements with the Southern Ute Indian Tribe of Colorado to assess and repair infrastructure so that it more suitably meets user needs. The funding that would be provided in this bill is an essential step toward assuring that both Indians and non-Indians have access to the water they need, when they need it. I look forward to working with my colleagues on both sides of the aisle to move this bill toward passage.

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. 1264

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 ''Pine River Indian Irrigation Project Act of 2009''.

SEC. 2. FINDINGS; PURPOSE.

(a) FINDINGS.—Congress finds that—

(1) drought, population increases, and environmental needs are exacerbating water supply issues across the western United States, including on the Southern Ute Indian Reservation in southwestern Colorado;

(2)(A) a report of the Government Accountability Office dated 2006 identified significant issues with the Pine River Indian Irrigation Project, including the issue that, at the time of the study, the Bureau of Indian Affairs estimated that total deferred maintenance costs for the Project exceeded $20,000,000; and

(B) other estimates have placed those costs at more than $60,000,000;

(3) the report of the Government Accountability Office demonstrates that key facilities of the Project are severely deteriorated;

(4) operations and maintenance fees are not sufficient to address the condition of the Project, even though the Bureau of Indian Affairs has sought to double those fees, from $8.50 to $17, in recent years;

(5) the report of the Government Accountability Office also notes that a prior study done by the Bureau of Reclamation determined that water users could not afford to pay operations and maintenance fees of $8.50 and operate a profitable farming operation;

(6) the benefits of rehabilitating and repairing the irrigation infrastructure of the Project include—

(A) water conservation;
(B) extending available water supply;
(C) increased agricultural production;
(D) economic benefits;
(E) safer facilities; and
(F) the preservation of the culture of the Southern Ute Indian Tribe;

(7) while, as of the date of enactment of this Act, the Project is managed by the Bureau of Indian Affairs, the Southern Ute Indian Tribe also receives water from facilities owned or operated by the Bureau of Reclamation; and

(8) rehabilitation and repair of the infrastructure of the Project by the Bureau of Reclamation would improve—

(A) overall water management; and

(B) the ability of the Southern Ute Indian Tribe and the Bureau of Reclamation to address potential water conflicts.

(b) PURPOSE.—The purpose of this Act is to require the Secretary of the Interior—

(1) to assess the condition of infrastructure of the Pine River Indian Irrigation Project;

(2) to establish priorities for the rehabilitation of irrigation infrastructure within the Project according to specified criteria; and

(3) to implement rehabilitation activities for the irrigation infrastructure of the Project.

SEC. 3. DEFINITIONS.

In this Act:

(1) PROJECT.—The term ''Project'' means the Pine River Indian Irrigation Project.

(2) SECRETARY.—The term ''Secretary'' means the Secretary of the Interior.

(3) STATE.—The term ''State'' means the State of Colorado.

(4) TRIBAL COUNCIL.—The term ''Tribal Council'' means the Southern Ute Indian Tribal Council.

(5) TRIBE.—The term ''Tribe'' means the Southern Ute Indian Tribe.

SEC. 4. STUDY OF IRRIGATION INFRASTRUCTURE OF PROJECT.

(a) STUDY.—

(1) IN GENERAL.—As soon as practicable after the date of enactment of this Act, the Secretary, in consultation with the Tribe, shall—

(A) conduct a study of the irrigation infrastructure of the Project; and

(B) based on the results of the study, develop a list of activities (including a cost estimate for each activity) that are recommended to be implemented during the 10-year period beginning on the date of completion of the study to repair, rehabilitate, or reconstruct that irrigation infrastructure.

(2) FACTORS FOR CONSIDERATION.—

(A) IN GENERAL.—In developing the list under paragraph (1)(B), the Secretary shall give priority to activities based on—

(i) a review of the priority factors described in subparagraph (B) with respect to the activity;

(ii) recommendations of the Tribe, if any; and

(iii) a consideration of the projected benefits of each activity on completion of the Project.

(B) PRIORITY FACTORS.—The priority factors referred to in subparagraph (A)(i) are—

(i) any threat to the health and safety of—

(I) a member of the Tribe;

(II) an employee of the irrigation operations and maintenance program of the Bureau of Indian Affairs; or

(III) the general public;

(ii) the extent of disrepair of the irrigation infrastructure of the Project and the effect of the disrepair on the ability of users of the Project to irrigate agricultural land using that irrigation infrastructure;

(iii) whether, and the extent to which, the repair, rehabilitation, or reconstruction of the irrigation infrastructure of the Project would provide an opportunity to conserve water;

(iv)(I) the economic and cultural impacts the irrigation infrastructure of the Project that is in disrepair has on the Tribe; and

(II) the economic and cultural benefits that the repair, rehabilitation, or reconstruction of that irrigation infrastructure would have on the Tribe;

(v) the opportunity to address water supply or environmental conflicts if the irrigation infrastructure of the Project is repaired, rehabilitated, or reconstructed; and

(vi) the overall benefits of the activity to efficient water operations on the land of the Tribe.

(3) CONSULTATION.—In carrying out the study under this subsection, the Secretary shall consult with the Assistant Secretary for Indian Affairs and other relevant Federal and local officials to evaluate the extent to which programs under the jurisdiction of each Federal and local agency may be used to develop—

(A) the list of activities under paragraph (1)(B); or

(B) the report under subsection (b).

(b) REPORT.—

(1) IN GENERAL.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to the Committee on Energy and Natural Resources of the Senate, the Committee on Natural Resources of the House of Representatives, and the Tribe a report that includes—

(A) the list of activities recommended for implementation under subsection (a)(1)(B); and

(B) any findings of the Secretary with respect to—

(i) the study under subsection (a);

(ii) consideration of the factors described in subsection (a)(2); and

(iii) any consultation required under subsection (a)(3).

(2) BIENNIAL REVIEW.—Not later than 2 years after the date on which the Secretary submits the report under paragraph (1) and every 2 years thereafter, the Secretary, in consultation with the Tribe, shall—

(A) review the report; and

(B) update the list of activities under subsection (a)(1)(B) in accordance with each factor described in subsection (a)(2), as the Secretary determines to be appropriate.

SEC. 5. IRRIGATION INFRASTRUCTURE GRANTS AND AGREEMENTS.

(a) IN GENERAL.—Subject to subsection (b), the Secretary may provide grants to, and enter into cooperative agreements with, the Tribe to plan, design, construct, or otherwise implement any activity to repair, rehabilitate, reconstruct, or replace irrigation infrastructure of the Project, if the activity is recommended for implementation on the list under section 4(a)(1)(B).

(b) LIMITATION.—Assistance provided under subsection (a) shall not be used for any on-farm improvement.

(c) CONSULTATION AND COORDINATION.—In providing assistance under subsection (a), the Secretary shall—

(1) consult with, and obtain the approval of, the Tribe;

(2) consult with the Assistant Secretary for Indian Affairs; and

(3) as appropriate, coordinate the activity with any work being conducted under the irrigation operations and maintenance program of the Bureau of Indian Affairs.

(d) COST SHARING REQUIREMENT.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Federal share of the total cost of carrying out an activity using assistance under subsection (a) shall be not more than 75 percent.

(2) EXCEPTION.—The Secretary may waive or limit the non-Federal share required under paragraph (1) on request of the Tribe.

SEC. 6. EFFECT OF ACT.

(a) WATER RIGHTS OF TRIBE.—Nothing in this Act (including the implementation of any activity carried out in accordance with this Act) affects any right of the Tribe to receive, divert, store, or claim a right to water, including the priority of right and the quantity of water associated with the water right under Federal or State law.

(b) STATE WATER LAW.—Nothing in this Act preempts or affects—

(1) any provision of water law of the State; or

(2) any interstate compact governing water.

SEC. 7. AUTHORIZATION OF APPROPRIATIONS.

(a) STUDY.—There is authorized to be appropriated to carry out the study under section 4 $4,000,000.

(b) IRRIGATION INFRASTRUCTURE GRANTS AND AGREEMENTS.—There is authorized to be appropriated to carry out section 5 $10,000,000 for each of fiscal years 2010 through 2015.

SUBMITTED RESOLUTIONS

SENATE CONCURRENT RESOLUTION 27—DIRECTING THE ARCHITECT OF THE CAPITOL TO ENGRAVE THE PLEDGE OF ALLEGIANCE TO THE FLAG AND THE NATIONAL MOTTO OF ''IN GOD WE TRUST'' IN THE CAPITOL VISITOR CENTER

Mr. DEMINT (for himself, Mr. BARRASSO, Mr. BROWNBACK, Mr. BUNNING, Mr. BYRD, Mr. CRAPO, Mr. ENZI, Mr. INHOFE, Mr. THUNE, and Mr. WICKER) submitted the following concurrent resolution; which was referred to the Committee on Rules and Administration:

S. CON. RES. 27

Resolved by the Senate (the House of Representatives concurring),

SECTION 1. ENGRAVING OF PLEDGE OF ALLEGIANCE TO THE FLAG AND NATIONAL MOTTO IN CAPITOL VISITOR CENTER.

(a) ENGRAVING REQUIRED.—The Architect of the Capitol shall engrave the Pledge of Allegiance to the Flag and the National Motto of ''In God we trust'' in the Capitol Visitor Center, in accordance with the engraving plan described in subsection (b).

(b) ENGRAVING PLAN.—The engraving plan described in this subsection is a plan setting forth the design and location of the engraving required under subsection (a) which is prepared by the Architect of the Capitol and approved by the Committee on House Administration of the House of Representatives and the Committee on Rules and Administration of the Senate.

SIGNING AUTHORITY

Mr. REID. Mr. President, I ask unanimous consent that the majority leader be authorized to sign duly enrolled bills or joint resolutions from Monday, June 15 to Wednesday, June 18.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

ORDERS FOR TUESDAY, JUNE 16, 2009

Mr. REID. I ask unanimous consent that when the Senate completes its business today, it adjourn until 10 a.m. tomorrow, Tuesday, June 16; that following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and there be a period of morning business for 1 hour with the time equally divided and controlled between the two leaders or their designees, with the majority controlling the first half and the Republicans controlling the final half, with Senators permitted to speak for up to 10 minutes each; finally, I ask unanimous consent that the Senate recess from 12:30 p.m. until 2:15 p.m. to allow for the weekly caucus luncheons.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.