

110TH CONGRESS  
2D SESSION

# H. R. 7192

To amend the Public Health Service Act and the Social Security Act to increase the number of primary care physicians and to improve patient access to primary care services, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 27, 2008

Ms. SCHWARTZ introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on the Judiciary, Education and Labor, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

To amend the Public Health Service Act and the Social Security Act to increase the number of primary care physicians and to improve patient access to primary care services, and for other purposes.

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

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

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

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

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

#### TITLE I—MEDICAL EDUCATION

- Sec. 101. Recruitment incentives.  
 Sec. 102. Debt forgiveness, scholarships, and service obligations.  
 Sec. 103. Deferment of loans during residency and internships.  
 Sec. 104. Immigration and Nationality provisions.  
 Sec. 105. Educating Medical Students about Primary Care Careers.

#### TITLE II—MEDICAID RELATED PROVISIONS

- Sec. 201. Transformation grants to support patient centered medical homes under Medicaid and SCHIP.  
 Sec. 202. Promoting Children’s Access to Covered Health Services.

#### TITLE III—MEDICARE PROVISIONS

##### Subtitle A—Primary Care

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

##### Subtitle B—Preventive Services

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

##### Subtitle C—Other Provisions

- Sec. 321. HHS study and report on improving the ability of physicians to assist Medicare beneficiaries in obtaining needed prescriptions under Medicare part D.  
 Sec. 322. Quality Improvement Organization Assistance for Physician Practices seeking to be patient-centered medical home practices.  
 Sec. 323. HHS study and report on improved patient care through increased caregiver and physician interaction.

- Sec. 324. Improved patient care through expanded support for Limited English Proficiency services.
- Sec. 325. HHS study and report on use of real-time Medicare claims adjudication.

#### TITLE IV—STUDIES

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

### 1 **SEC. 2. FINDINGS.**

2 Congress makes the following findings:

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

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

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

16 (4) In 2006, only 24 percent of third-year inter-  
17 nal medicine resident intended to pursue careers in  
18 general internal medicine, down from 54 percent in  
19 1998.

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

5           (6) Primary care physicians practicing preven-  
6 tive care, including screening for illness and treating  
7 diseases, can help prevent complications that result  
8 in more costly care.

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

13           (8) Higher proportions of primary care physi-  
14 cians are associated with significantly reduced utili-  
15 zation.

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

21           (10) The number of Americans age 65 and  
22 older, those eligible for Medicare and who use far  
23 more ambulatory care visits per person as those  
24 under age 65, is expected to double from 2000 to  
25 2030.

1           (11) A decrease in Federal spending to carry  
2 out programs authorized by title VII of the Public  
3 Health Service Act threatens the viability of one of  
4 the programs used to solve the problem of inad-  
5 equate access to primary care.

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

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

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

19 **SEC. 3. DEFINITIONS.**

20           (a) **GENERAL DEFINITIONS.**—In this Act:

21           (1) **CHRONIC CARE COORDINATION.**—In this  
22 Act, the term “chronic care coordination” means the  
23 coordination of services that is based on the Chronic  
24 Care Model that provides on-going health care to pa-

1       tients with chronic diseases that may include any of  
2       the following services:

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

6               (B) The management of, and referral for,  
7               medical and other health services, including  
8               interdisciplinary care conferences and manage-  
9               ment with other providers.

10              (C) The monitoring and management of  
11              medications.

12              (D) Patient education and counseling serv-  
13              ices.

14              (E) Family caregiver education and coun-  
15              seling services.

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

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

23              (H) Management with the principal non-  
24              professional caregiver in the home.

1 (I) Managing and facilitating transitions  
2 among health care professionals and across set-  
3 tings of care, including the following:

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

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

9 (J) Information about, and referral to,  
10 hospice care, including patient and family care-  
11 giver education and counseling about hospice  
12 care, and facilitating transition to hospice care  
13 when elected.

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

16 (L) Such additional services for which pay-  
17 ment would not otherwise be made under this  
18 title that the Secretary may specify that en-  
19 courage the receipt of, or improve the effective-  
20 ness of, the services described in this para-  
21 graph.

22 (2) CRITICAL SHORTAGE HEALTH FACILITY.—

23 The term “critical shortage health facility” means a  
24 public or private nonprofit health facility that does  
25 not serve a health professional shortage area (as

1 designated under section 332 of the Public Health  
2 Service Act), but that has a critical shortage of phy-  
3 sicians (as determined by the Secretary) in the field  
4 of family practice, internal medicine and pediatrics.

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

13 (4) PRIMARY CARE PHYSICIAN.—The term “pri-  
14 mary care physician” means a physician (as defined  
15 in section 1886 of the Social Security Act) who is  
16 trained in the fields of family practice, internal med-  
17 icine, and pediatrics who provides first contact, con-  
18 tinuous, and comprehensive care to patients.

19 (5) PRINCIPAL CARE.—The term “principal  
20 care” means integrated, accessible health care that  
21 is provided by medical subspecialists that addresses  
22 the majority of the personal health care needs of pa-  
23 tients with chronic conditions requiring the sub-  
24 specialist’s expertise, and for whom the subspecialist  
25 assumes care management, developing a sustained

1 physician-patient partnership and practicing within  
2 the context of family and community.

3 (6) SECRETARY.—The term “Secretary” means  
4 the Secretary of Health and Human Services.

5 (b) PRIMARY MEDICAL CARE SHORTAGE AREA.—

6 (1) IN GENERAL.—In this Act, the term “pri-  
7 mary medical care shortage area” or “PMCSA”  
8 means a geographic area with a shortage of physi-  
9 cians (as designated by the Secretary) in the field of  
10 family practice, internal medicine, or pediatrics, as  
11 designated in accordance with paragraph (2).

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

19 (A) The area is a rational area for the de-  
20 livery of primary medical care services.

21 (B) One of the following conditions pre-  
22 vails within the area—

23 (i) the area has a population to full-  
24 time-equivalent primary care physician  
25 ratio of at least 3,500 to 1; or

1 (ii) the area has a population to full-  
2 time-equivalent primary care physician  
3 ratio of less than 3,500 to 1 but greater  
4 than 3,000 to 1 and has unusually high  
5 needs for primary care services or insuffi-  
6 cient capacity of existing primary care pro-  
7 viders.

8 (C) Primary medical care professionals in  
9 contiguous geographic areas are over-utilized.

10 (c) MEDICALLY UNDERSERVED AREA.—

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

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

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

4           (A) The ratio of primary medical care phy-  
5 sicians per 1,000 individuals in the population  
6 of the area involved.

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

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

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

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

17 (d) PATIENT CENTERED MEDICAL HOME.—

18           (1) IN GENERAL.—In this Act, the term “pa-  
19 tient centered medical home” means a physician-di-  
20 rected practice that has been certified by an organi-  
21 zation under paragraph (2) as meeting the following  
22 standards:

23           (A) The practice provides patients who  
24 elect to obtain care through a patient centered  
25 medical home (referred to as “participating pa-

1           tients”) with direct and ongoing access to a pri-  
2           mary or principal care physician who accepts  
3           responsibility for providing first contact, contin-  
4           uous, and comprehensive care to the whole per-  
5           son, in collaboration with teams of other health  
6           professionals, including nurses and specialist  
7           physicians, as needed and appropriate.

8           (B) The practice applies standards for ac-  
9           cess to care and communication with partici-  
10          pating beneficiaries.

11          (C) The practice has readily accessible,  
12          clinically useful information on participating pa-  
13          tients that enables the practice to treat such  
14          patients comprehensively and systematically.

15          (D) The practice maintains continuous re-  
16          lationships with participating patients by imple-  
17          menting evidence-based guidelines and applying  
18          such guidelines to the identified needs of indi-  
19          vidual beneficiaries over time and with the in-  
20          tensity needed by such beneficiaries.

21          (E) The practice—

22               (i) collaborates with participating pa-  
23               tients to pursue their goals for optimal  
24               achievable health; and

1                   (ii) assesses patient-specific barriers  
2                   to communication and conducts activities  
3                   to support patient self-management.

4                   (F) The practice has in place the resources  
5                   and processes necessary to achieve improve-  
6                   ments in the management and coordination of  
7                   care for participating patients.

8                   (G) The practice monitors its clinical proc-  
9                   ess and performance (including outcome meas-  
10                  ures) in meeting the applicable standards under  
11                  this paragraph and provides information in a  
12                  form and manner specified by the Secretary  
13                  with respect to such process and performance.

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

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

22                         (B) to provide for the review and certifi-  
23                         cation of medical practices as meeting such  
24                         standards.

1 **TITLE I—MEDICAL EDUCATION**

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

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

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

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

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

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

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

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

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

4           “(3) Increased opportunities for ambulatory,  
5           community-based training.

6           “(d) AUTHORIZATION OF APPROPRIATIONS.—There  
7           is authorized to be appropriated to carry out this section  
8           \$50,000,000 for each of the fiscal years 2010 through  
9           2012.”.

10   **SEC. 102. DEBT FORGIVENESS, SCHOLARSHIPS, AND SERV-**  
11                           **ICE OBLIGATIONS.**

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

15           (b) AMENDMENT TO THE PUBLIC HEALTH SERVICE  
16           ACT.—Part D of title III of the Public Health Service Act  
17           (42 U.S.C. 254b et seq.) is amended by adding at the end  
18           the following:

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

20           **“SEC. 340I. SCHOLARSHIPS.**

21           “(a) IN GENERAL.—The Secretary, acting through  
22           the Administrator of the Health Resources and Services  
23           Administration, shall award grants to critical shortage  
24           health facilities to enable such facilities to provide scholar-  
25           ships to individuals who agree to serve as physicians at

1 such facilities after completing a residency in the field of  
2 family practice, pediatrics, or internal medicine.

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

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

11 “(2) the individual agrees—

12 “(A) to maintain an acceptable level of  
13 academic standing;

14 “(B) to complete a residency in the field of  
15 family practice, internal medicine, or pediatrics;  
16 and

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

21 “(i) one year for each school year for  
22 which the individual was provided a schol-  
23 arship under this section; or

24 “(ii) two years.

25 “(c) AMOUNT.—

1           “(1) IN GENERAL.—The amount paid by a  
2 health facility to an individual under a scholarship  
3 under this section shall not exceed \$30,000 for any  
4 school year.

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

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

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

21           “(e) DEFINITIONS.—In this section:

22           “(1) CRITICAL SHORTAGE HEALTH FACILITY.—  
23 The term ‘critical shortage health facility’ means a  
24 public or private nonprofit health facility that does  
25 not serve a health professional shortage area (as

1 designated under section 332), but has a critical  
2 shortage of physicians (as determined by the Sec-  
3 retary) in the field of family practice, internal medi-  
4 cine, or pediatrics.

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

10 “(f) AUTHORIZATION OF APPROPRIATIONS.—To  
11 carry out this section, there is authorized to be appro-  
12 priated \$5,000,000 for each of fiscal years 2009 through  
13 2013.

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

15 “(a) PURPOSE.—It is the purpose of this section to  
16 alleviate critical shortages of physicians in the fields of  
17 family practice, internal medicine, and pediatrics.

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

23 “(1) the individual agrees to serve—

1           “(A) as a primary care physician in the  
2           field of family practice, internal medicine, or  
3           pediatrics; and

4           “(B) in an area that is not a health profes-  
5           sional shortage area (as designated under sec-  
6           tion 332), but has a critical shortage of physi-  
7           cians (as determined by the Secretary) in such  
8           field; and

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

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

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

1       “(e) DEFINITION.—In this section, the term ‘eligible  
2 individual’ means an individual with a degree in medicine  
3 or osteopathic medicine.

4       “(f) AUTHORIZATION OF APPROPRIATIONS.—To  
5 carry out this section, there is authorized to be appro-  
6 priated \$5,000,000 for each of fiscal years 2009 through  
7 2013.

8       **“SEC. 340K. REPORTS.**

9       “Not later than 18 months after the date of enact-  
10 ment of this Act, and annually thereafter, the Secretary  
11 shall submit to Congress a report that describes the pro-  
12 grams carried out under this subpart, including state-  
13 ments concerning—

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

16               “(2) the number of graduates;

17               “(3) the amount of scholarship payments and  
18               loan repayments made;

19               “(4) which educational institution the recipients  
20               attended;

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

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

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

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

5           “(9) the demographics of the individuals par-  
6           ticipating in the scholarship and loan repayment  
7           programs;

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

11          “(11) an evaluation of the overall costs and  
12          benefits of the programs.”.

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

15          (a) **LOAN REQUIREMENTS.**—Section 427(a)(2)(C)(i)  
16 of the Higher Education Act of 1965 (20 U.S.C.  
17 1077(a)(2)(C)(i)) is amended by inserting “unless the  
18 medical internship or residency program is in family medi-  
19 cine, internal medicine, or pediatric medicine” after “resi-  
20 dency program”.

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

1 cine, internal medicine, or pediatric medicine” after “resi-  
2 dency program”.

3 (c) FEDERAL DIRECT LOANS.—Section 455(f)(2)(A)  
4 of the Higher Education Act of 1965 (20 U.S.C.  
5 1087e(f)(2)(A)) is amended by inserting “unless the med-  
6 ical internship or residency program is in family medicine,  
7 internal medicine, or pediatric medicine” after “residency  
8 program”.

9 (d) FEDERAL PERKINS LOANS.—Section  
10 464(c)(2)(A)(i) of the Higher Education Act of 1965 (20  
11 U.S.C. 1087dd(c)(2)(A)(i)) is amended by inserting “un-  
12 less the medical internship or residency program is in fam-  
13 ily medicine, internal medicine, or pediatric medicine”  
14 after “residency program”.

15 **SEC. 104. IMMIGRATION AND NATIONALITY PROVISIONS.**

16 (a) CONRAD STATE 30 J-1 VISA WAIVER PRO-  
17 GRAM.—Section 220(c) of the Immigration and Nation-  
18 ality Technical Corrections Act of 1994 (8 U.S.C. 1182  
19 note) is amended by striking “and before June 1, 2008”.

20 (b) EXEMPTION TO H-1B VISA LIMITATION.—Sec-  
21 tion 214(g)(5) of the Immigration and Nationality Act (8  
22 U.S.C. 1184(g)(5)) is amended—

23 (1) in subparagraph (B), by striking “or” at  
24 the end;

1 (2) in subparagraph (C), by striking the period  
2 at the end and inserting “; or”; and

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

4 “(D) has been awarded a medical specialty cer-  
5 tification in internal medicine, pediatrics, or family  
6 medicine by the appropriate medical board based on  
7 post-doctoral training and experience in the United  
8 States.”.

9 **SEC. 105. EDUCATING MEDICAL STUDENTS ABOUT PRI-**  
10 **MARY CARE CAREERS.**

11 Part C of title VII of the Public Health Service Act  
12 (42 U.S.C. 293k) is amended by adding at the end the  
13 following:

14 **“SEC. 749. EDUCATING MEDICAL STUDENTS ABOUT PRI-**  
15 **MARY CARE CAREERS.**

16 “(a) IN GENERAL.—The Secretary shall award  
17 grants to eligible State and local government entities for  
18 the development of informational materials that promote  
19 careers in primary care by highlighting the advantages  
20 and rewards of primary care, and that encourage medical  
21 students, particularly students from disadvantaged back-  
22 grounds, to become primary care physicians.

23 “(b) ANNOUNCEMENT.—The grants described in sub-  
24 section (a) shall be announced through a publication in  
25 the Federal Register and through appropriate media out-

1 lets in a manner intended to reach medical education insti-  
2 tutions, associations, physician groups, and others who  
3 communicate with medical students.

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

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

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

10 “(d) USE OF FUNDS.—

11 “(1) IN GENERAL.—An entity shall use  
12 amounts received under a grant under this section to  
13 support State and local campaigns through appro-  
14 priate media outlets to promote careers in primary  
15 care and to encourage individuals from disadvan-  
16 taged backgrounds to enter and pursue careers in  
17 primary care.

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

23 “(A) advertise and promote careers in pri-  
24 mary care;

1           “(B) promote primary care medical edu-  
2 cation programs;

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

5           “(D) highlight individuals in the commu-  
6 nity who are practicing primary care physicians  
7 in order to recruit physicians; or

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

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

13       “(f) AUTHORIZATION OF APPROPRIATIONS.—There  
14 is authorized to be appropriated to carry out this section,  
15 such sums as may be necessary for each of fiscal years  
16 2009 through 2012.”.

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

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

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

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

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

12          (2) in paragraph (4)—

13                 (A) in subparagraph (A)—

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

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

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

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

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



1 “(b) DUTIES.—

2 “(1) REVIEW OF ACCESS POLICIES AND AN-  
3 NUAL REPORTS.—MACPAC shall—

4 “(A) review policies of the Medicaid pro-  
5 gram established under this title (in this section  
6 referred to as ‘Medicaid’) and the State Chil-  
7 dren’s Health Insurance Program established  
8 under title XXI (in this section referred to as  
9 ‘CHIP’) affecting access to covered items and  
10 services, including topics described in paragraph  
11 (2);

12 “(B) make recommendations to Congress  
13 concerning such access policies;

14 “(C) by not later than March 1 of each  
15 year (beginning with 2009), submit a report to  
16 Congress containing the results of such reviews  
17 and MACPAC’s recommendations concerning  
18 such policies; and

19 “(D) by not later than June 1 of each year  
20 (beginning with 2009), submit a report to Con-  
21 gress containing an examination of issues af-  
22 fecting Medicaid and CHIP, including the im-  
23 plications of changes in health care delivery in  
24 the United States and in the market for health  
25 care services on such programs.

1           “(2) SPECIFIC TOPICS TO BE REVIEWED.—Spe-  
2           cifically, MACPAC shall review and assess the fol-  
3           lowing:

4                   “(A) MEDICAID AND CHIP PAYMENT POLI-  
5                   CIES.—Payment policies under Medicaid and  
6                   CHIP, including—

7                           “(i) the factors affecting expenditures  
8                           for items and services in different sectors,  
9                           including the process for updating hospital,  
10                           skilled nursing facility, physician, federally  
11                           qualified health center, rural health center,  
12                           and other fees;

13                           “(ii) payment methodologies; and

14                           “(iii) the relationship of such factors  
15                           and methodologies to access and quality of  
16                           care for Medicaid and CHIP beneficiaries.

17                   “(B) INTERACTION OF MEDICAID AND  
18                   CHIP PAYMENT POLICIES WITH HEALTH CARE  
19                   DELIVERY GENERALLY.—The effect of Medicaid  
20                   and CHIP payment policies on access to items  
21                   and services for children and other Medicaid  
22                   and CHIP populations other than under this  
23                   title or title XXI and the implications of  
24                   changes in health care delivery in the United

1 States and in the general market for health  
2 care items and services on Medicaid and CHIP.

3 “(C) OTHER ACCESS POLICIES.—The ef-  
4 fect of other Medicaid and CHIP policies on ac-  
5 cess to covered items and services, including  
6 policies relating to transportation and language  
7 barriers.

8 “(3) CREATION OF EARLY-WARNING SYSTEM.—  
9 MACPAC shall create an early-warning system to  
10 identify provider shortage areas or any other prob-  
11 lems that threaten access to care or the health care  
12 status of Medicaid and CHIP beneficiaries.

13 “(4) COMMENTS ON CERTAIN SECRETARIAL RE-  
14 PORTS.—If the Secretary submits to Congress (or a  
15 committee of Congress) a report that is required by  
16 law and that relates to access policies, including with  
17 respect to payment policies, under Medicaid or  
18 CHIP, the Secretary shall transmit a copy of the re-  
19 port to MACPAC. MACPAC shall review the report  
20 and, not later than 6 months after the date of sub-  
21 mittal of the Secretary’s report to Congress, shall  
22 submit to the appropriate committees of Congress  
23 written comments on such report. Such comments  
24 may include such recommendations as MACPAC  
25 deems appropriate.

1           “(5) AGENDA AND ADDITIONAL REVIEWS.—  
2           MACPAC shall consult periodically with the chair-  
3           men and ranking minority members of the appro-  
4           priate committees of Congress regarding MACPAC’s  
5           agenda and progress towards achieving the agenda.  
6           MACPAC may conduct additional reviews, and sub-  
7           mit additional reports to the appropriate committees  
8           of Congress, from time to time on such topics relat-  
9           ing to the program under this title or title XXI as  
10          may be requested by such chairmen and members  
11          and as MACPAC deems appropriate.

12          “(6) AVAILABILITY OF REPORTS.—MACPAC  
13          shall transmit to the Secretary a copy of each report  
14          submitted under this subsection and shall make such  
15          reports available to the public.

16          “(7) APPROPRIATE COMMITTEE OF CON-  
17          GRESS.—For purposes of this section, the term ‘ap-  
18          propriate committees of Congress’ means the Com-  
19          mittee on Energy and Commerce of the House of  
20          Representatives and the Committee on Finance of  
21          the Senate.

22          “(8) VOTING AND REPORTING REQUIRE-  
23          MENTS.—With respect to each recommendation con-  
24          tained in a report submitted under paragraph (1),  
25          each member of MACPAC shall vote on the rec-

1 ommendation, and MACPAC shall include, by mem-  
2 ber, the results of that vote in the report containing  
3 the recommendation.

4 “(9) EXAMINATION OF BUDGET CON-  
5 SEQUENCES.—Before making any recommendations,  
6 MACPAC shall examine the budget consequences of  
7 such recommendations, directly or through consulta-  
8 tion with appropriate expert entities.

9 “(c) MEMBERSHIP.—

10 “(1) NUMBER AND APPOINTMENT.—MACPAC  
11 shall be composed of 17 members appointed by the  
12 Comptroller General of the United States.

13 “(2) QUALIFICATIONS.—

14 “(A) IN GENERAL.—The membership of  
15 MACPAC shall include individuals who have  
16 had direct experience as enrollees or parents of  
17 enrollees in Medicaid or CHIP and individuals  
18 with national recognition for their expertise in  
19 Federal safety net health programs, health fi-  
20 nance and economics, actuarial science, health  
21 facility management, health plans and inte-  
22 grated delivery systems, reimbursement of  
23 health facilities, health information technology,  
24 pediatric physicians, dentists, and other pro-  
25 viders of health services, and other related

1 fields, who provide a mix of different profes-  
2 sionals, broad geographic representation, and a  
3 balance between urban and rural representa-  
4 tives.

5 “(B) INCLUSION.—The membership of  
6 MACPAC shall include (but not be limited to)  
7 physicians and other health professionals, em-  
8 ployers, third-party payers, and individuals with  
9 expertise in the delivery of health services. Such  
10 membership shall also include consumers rep-  
11 resenting children, pregnant women, the elderly,  
12 and individuals with disabilities, current or  
13 former representatives of State agencies respon-  
14 sible for administering Medicaid, and current or  
15 former representatives of State agencies respon-  
16 sible for administering CHIP.

17 “(C) MAJORITY NONPROVIDERS.—Individ-  
18 uals who are directly involved in the provision,  
19 or management of the delivery, of items and  
20 services covered under Medicaid or CHIP shall  
21 not constitute a majority of the membership of  
22 MACPAC.

23 “(D) ETHICAL DISCLOSURE.—The Comp-  
24 troller General of the United States shall estab-  
25 lish a system for public disclosure by members

1 of MACPAC of financial and other potential  
2 conflicts of interest relating to such members.  
3 Members of MACPAC shall be treated as em-  
4 ployees of Congress for purposes of applying  
5 title I of the Ethics in Government Act of 1978  
6 (Public Law 95–521).

7 “(3) TERMS.—

8 “(A) IN GENERAL.—The terms of mem-  
9 bers of MACPAC shall be for 3 years except  
10 that the Comptroller General of the United  
11 States shall designate staggered terms for the  
12 members first appointed.

13 “(B) VACANCIES.—Any member appointed  
14 to fill a vacancy occurring before the expiration  
15 of the term for which the member’s predecessor  
16 was appointed shall be appointed only for the  
17 remainder of that term. A member may serve  
18 after the expiration of that member’s term until  
19 a successor has taken office. A vacancy in  
20 MACPAC shall be filled in the manner in which  
21 the original appointment was made.

22 “(4) COMPENSATION.—While serving on the  
23 business of MACPAC (including travel time), a  
24 member of MACPAC shall be entitled to compensa-  
25 tion at the per diem equivalent of the rate provided

1 for level IV of the Executive Schedule under section  
2 5315 of title 5, United States Code; and while so  
3 serving away from home and the member's regular  
4 place of business, a member may be allowed travel  
5 expenses, as authorized by the Chairman of  
6 MACPAC. Physicians serving as personnel of  
7 MACPAC may be provided a physician comparability  
8 allowance by MACPAC in the same manner as Gov-  
9 ernment physicians may be provided such an allow-  
10 ance by an agency under section 5948 of title 5,  
11 United States Code, and for such purpose subsection  
12 (i) of such section shall apply to MACPAC in the  
13 same manner as it applies to the Tennessee Valley  
14 Authority. For purposes of pay (other than pay of  
15 members of MACPAC) and employment benefits,  
16 rights, and privileges, all personnel of MACPAC  
17 shall be treated as if they were employees of the  
18 United States Senate.

19 “(5) CHAIRMAN; VICE CHAIRMAN.—The Comp-  
20 troller General of the United States shall designate  
21 a member of MACPAC, at the time of appointment  
22 of the member as Chairman and a member as Vice  
23 Chairman for that term of appointment, except that  
24 in the case of vacancy of the Chairmanship or Vice  
25 Chairmanship, the Comptroller General of the

1 United States may designate another member for  
2 the remainder of that member's term.

3 “(6) MEETINGS.—MACPAC shall meet at the  
4 call of the Chairman.

5 “(d) DIRECTOR AND STAFF; EXPERTS AND CON-  
6 SULTANTS.—Subject to such review as the Comptroller  
7 General of the United States deems necessary to assure  
8 the efficient administration of MACPAC, MACPAC  
9 may—

10 “(1) employ and fix the compensation of an Ex-  
11 ecutive Director (subject to the approval of the  
12 Comptroller General of the United States) and such  
13 other personnel as may be necessary to carry out its  
14 duties (without regard to the provisions of title 5,  
15 United States Code, governing appointments in the  
16 competitive service);

17 “(2) seek such assistance and support as may  
18 be required in the performance of its duties from ap-  
19 propriate Federal departments and agencies;

20 “(3) enter into contracts or make other ar-  
21 rangements, as may be necessary for the conduct of  
22 the work of MACPAC (without regard to section  
23 3709 of the Revised Statutes (41 U.S.C. 5));

24 “(4) make advance, progress, and other pay-  
25 ments which relate to the work of MACPAC;

1           “(5) provide transportation and subsistence for  
2 persons serving without compensation; and

3           “(6) prescribe such rules and regulations as it  
4 deems necessary with respect to the internal organi-  
5 zation and operation of MACPAC.

6           “(e) POWERS.—

7           “(1) OBTAINING OFFICIAL DATA.—MACPAC  
8 may secure directly from any department or agency  
9 of the United States information necessary to enable  
10 it to carry out this section. Upon request of the  
11 Chairman, the head of that department or agency  
12 shall furnish that information to MACPAC on an  
13 agreed upon schedule.

14           “(2) DATA COLLECTION.—In order to carry out  
15 its functions, MACPAC shall—

16           “(A) utilize existing information, both pub-  
17 lished and unpublished, where possible, collected  
18 and assessed either by its own staff or under  
19 other arrangements made in accordance with  
20 this section;

21           “(B) carry out, or award grants or con-  
22 tracts for, original research and experimen-  
23 tation, where existing information is inad-  
24 equate; and

1           “(C) adopt procedures allowing any inter-  
2           ested party to submit information for  
3           MACPAC’s use in making reports and rec-  
4           ommendations.

5           “(3) ACCESS OF GAO TO INFORMATION.—The  
6           Comptroller General of the United States shall have  
7           unrestricted access to all deliberations, records, and  
8           nonproprietary data of MACPAC, immediately upon  
9           request.

10           “(4) PERIODIC AUDIT.—MACPAC shall be sub-  
11           ject to periodic audit by the Comptroller General of  
12           the United States.

13           “(f) AUTHORIZATION OF APPROPRIATIONS.—

14           “(1) REQUEST FOR APPROPRIATIONS.—  
15           MACPAC shall submit requests for appropriations  
16           in the same manner as the Comptroller General of  
17           the United States submits requests for appropria-  
18           tions, but amounts appropriated for MACPAC shall  
19           be separate from amounts appropriated for the  
20           Comptroller General of the United States.

21           “(2) AUTHORIZATION.—There are authorized to  
22           be appropriated such sums as may be necessary to  
23           carry out the provisions of this section.”.

24           (b) DEADLINE FOR INITIAL APPOINTMENTS.—Not  
25           later than January 1, 2009, the Comptroller General of

1 the United States shall appoint the initial members of the  
 2 Medicaid and CHIP Payment and Access Commission es-  
 3 tablished under section 1900 of the Social Security Act  
 4 (as added by subsection (a)).

5 **TITLE III—MEDICARE**  
 6 **PROVISIONS**

7 **Subtitle A—Primary Care**

8 **SEC. 301. REFORMING PAYMENT SYSTEMS UNDER MEDI-**  
 9 **CARE TO SUPPORT PRIMARY CARE.**

10 (a) INCREASING BUDGET NEUTRALITY LIMITS  
 11 UNDER THE PHYSICIAN FEE SCHEDULE TO ACCOUNT  
 12 FOR ANTICIPATED SAVINGS RESULTING FROM PAYMENTS  
 13 FOR CERTAIN SERVICES AND THE COORDINATION OF  
 14 BENEFICIARY CARE.—Section 1848(c)(2)(B) of the Social  
 15 Security Act (42 U.S.C. 1395w-4(c)(2)(B)), as amended  
 16 by section 133 of the Medicare Improvements for Patients  
 17 and Providers Act of 2008 (Public Law 110-275), is  
 18 amended—

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

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

23 “(vii) INCREASE IN LIMITATION TO  
 24 ACCOUNT FOR CERTAIN ANTICIPATED SAV-  
 25 INGS.—

1                   “(I) IN GENERAL.—Effective for  
2 fee schedules established beginning  
3 with 2009, the Secretary shall in-  
4 crease the limitation on annual ad-  
5 justments under clause (ii)(II) by an  
6 amount equal to the anticipated sav-  
7 ings under parts A, B, and D (includ-  
8 ing any savings with respect to items  
9 and services for which payment is not  
10 made under this section) which are a  
11 result of payments for designated pri-  
12 mary care services and comprehensive  
13 care coordination services under sec-  
14 tion 1834(m) and the coverage of pa-  
15 tient-centered medical home services  
16 under section 1861(s)(2)(FF) (as de-  
17 termined by the Secretary).

18                   “(II) MECHANISM TO DETER-  
19 MINE APPLICATION OF INCREASE.—  
20 The Secretary shall establish a mecha-  
21 nism for determining which relative  
22 value units established under this  
23 paragraph for physicians’ services  
24 shall be subject to an adjustment

1 under clause (ii)(I) as a result of the  
2 increase under subclause (I).

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

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

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

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

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

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

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

17          “(4) DEFINITIONS.—

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

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

10                   “(i) Care plan oversight.

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

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

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

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

20                   “(vi) Anticoagulation management  
21                   services.

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

1           (2) EFFECTIVE DATE.—The amendment made  
2           by this section shall apply to items and services fur-  
3           nished on or after January 1, 2009.

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

6           (a) IN GENERAL.—Section 1861(s)(2) of the Social  
7 Security Act (42 U.S.C. 1395x(s)(2)), as amended by sec-  
8 tion 152 of the Medicare Improvements for Patients and  
9 Providers Act of 2008 (Public Law 110–275), is amend-  
10 ed—

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

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

15           (3) by adding at the end the following new sub-  
16           paragraph:

17           “(FF) patient-centered medical home services  
18           (as defined in subsection (hhh)(1));”.

19           (b) DEFINITION OF PATIENT-CENTERED MEDICAL  
20 HOME SERVICES.—Section 1861 of the Social Security  
21 Act (42 U.S.C. 1395x), as amended by such section 152,  
22 is amended by adding at the end the following new sub-  
23 section:

1 “Patient-Centered Medical Home Services

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

5 “(2) The term ‘qualified patient-centered medical  
6 home’ means a patient-centered medical home which has  
7 been recognized as a patient-centered medical home  
8 through an appropriate process, including a patient-cen-  
9 tered medical home which is recognized through the Physi-  
10 cian Practice Connections—Patient-Centered Medical  
11 Home (‘PPC–PCMH’) voluntary recognition process of  
12 the National Committee for Quality Assurance (or any  
13 other equivalent process, as determined by the Sec-  
14 retary).”.

15 (c) MONTHLY FEE FOR PATIENT-CENTERED MED-  
16 ICAL HOME SERVICES.—Section 1848 of the Social Secu-  
17 rity Act (42 U.S.C. 1395w–4), as amended by section 131  
18 of the Medicare Improvements for Patients and Providers  
19 Act of 2008 (Public Law 110–275), is amended by adding  
20 at the end the following new subsection:

21 “(o) MONTHLY FEE FOR PATIENT-CENTERED MED-  
22 ICAL HOME SERVICES.—

23 “(1) MONTHLY FEE.—

24 “(A) IN GENERAL.—Not later than Janu-  
25 ary 1, 2012, the Secretary shall establish a pay-

1           ment methodology for patient-centered medical  
2           home services (as defined in paragraph (1) of  
3           section 1861(hhh)). Under such payment meth-  
4           odology, the Secretary shall pay qualified pa-  
5           tient-centered medical homes (as defined in  
6           paragraph (2) of such section) a monthly fee  
7           for each individual who elects to receive patient-  
8           centered medical home services at that medical  
9           home. Such fee shall be paid on a prospective  
10          basis.

11           “(B) CONSIDERATIONS.—The Secretary  
12          shall take into account the results of the Medi-  
13          care medical home demonstration project under  
14          section 204 of Division B of the Tax Relief and  
15          Health Care Act of 2008 (42 U.S.C. 1395b–1  
16          note) in establishing the payment methodology  
17          under subparagraph (A).

18          “(2) AMOUNT OF PAYMENT.—

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

22           “(i) The clinical work and practice ex-  
23          penses involved in providing care coordina-  
24          tion services consistent with the patient-  
25          centered medical home model (such as pro-

1           viding increased access, care coordination,  
2           disease population management, and edu-  
3           cation) for which payment is not made  
4           under this section as of the date of enact-  
5           ment of this subsection.

6           “(ii) Ensuring that the amount of  
7           payment is sufficient to support the acqui-  
8           sition, use, and maintenance of clinical in-  
9           formation systems which—

10                   “(I) are needed by a qualified pa-  
11                   tient-centered medical home (as so de-  
12                   fined); and

13                   “(II) have been shown to facili-  
14                   tate improved outcomes through care  
15                   coordination.

16           “(iii) The establishment of a tiered  
17           monthly care management fee that pro-  
18           vides for a range of payment depending on  
19           how advanced the capabilities of a qualified  
20           patient-centered medical home (as so de-  
21           fined) are in having the information sys-  
22           tems needed to support care coordination.

23           “(B) RISK-ADJUSTMENT.—The Secretary  
24           shall use appropriate risk-adjustment in deter-

1 mining the amount of the monthly fee under  
2 this paragraph.

3 “(3) FUNDING.—

4 “(A) IN GENERAL.—The Secretary shall  
5 determine the aggregate estimated savings for a  
6 calendar year as a result of the implementation  
7 of this subsection on reducing preventable hos-  
8 pital admissions, duplicate testing, medication  
9 errors and drug interactions, and other savings  
10 under this part and part A (including any sav-  
11 ings with respect to items and services for  
12 which payment is not made under this section).

13 “(B) FUNDING.—Subject to subparagraph  
14 (C), the aggregate amount available for pay-  
15 ment of the monthly fee under this subsection  
16 during a calendar year shall be equal to the ag-  
17 gregate estimated savings (as determined under  
18 subparagraph (A)) for the calendar year (as de-  
19 termined by the Secretary).

20 “(C) ADDITIONAL FUNDING.—In the case  
21 where the amount of the aggregate actual sav-  
22 ings during the preceding 3 years exceeds the  
23 amount of the aggregate estimated savings (as  
24 determined under subparagraph (A)) during  
25 such period, the aggregate amount available for

1 payment of the monthly fee under this sub-  
2 section during the calendar year (as determined  
3 under subparagraph (B)) shall be increased by  
4 the amount of such excess.

5 “(D) ADDITIONAL FUNDING AS DETER-  
6 MINED NECESSARY BY THE SECRETARY.—In  
7 addition to any funding made available under  
8 subparagraphs (B) and (C), there shall also be  
9 available to the Secretary, for purposes of effec-  
10 tively implementing this subsection, such addi-  
11 tional funds as the Secretary determines are  
12 necessary.

13 “(4) PERFORMANCE-BASED BONUS PAY-  
14 MENTS.—The Secretary shall establish a process for  
15 paying a performance-based bonus to qualified pa-  
16 tient-centered medical homes which meet or achieve  
17 substantial improvements in performance (as speci-  
18 fied under clinical, patient satisfaction, and effi-  
19 ciency benchmarks established by the Secretary).  
20 Such bonus shall be in an amount determined appro-  
21 priate by the Secretary.

22 “(5) NO EFFECT ON PAYMENTS FOR EVALUA-  
23 TION AND MANAGEMENT SERVICES.—The monthly  
24 fee under this subsection shall have no effect on the

1 amount of payment for evaluation and management  
2 services under this title.”.

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

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

6 (2) by inserting before the semicolon at the end  
7 the following: “, and (X) with respect to patient-cen-  
8 tered medical home services (as defined in section  
9 1861(hhh)(1)), the amount paid shall be (i) in the  
10 case of such services which are physicians’ services,  
11 the amount determined under subparagraph (N),  
12 and (ii) in the case of all other such services, 80 per-  
13 cent of the lesser of the actual charge for the service  
14 or the amount determined under a fee schedule es-  
15 tablished by the Secretary for purposes of this sub-  
16 paragraph”.

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

20 **SEC. 303. MEDICARE PRIMARY CARE PAYMENT EQUITY AND**  
21 **ACCESS PROVISION.**

22 (a) IN GENERAL.—Section 1848 of the Social Secu-  
23 rity Act (42 U.S.C. 1395w-4), as amended by section 202,  
24 is amended by adding at the end the following new sub-  
25 section:

1       “(p) PRIMARY CARE PAYMENT EQUITY AND AC-  
2 CESS.—

3           “(1) IN GENERAL.—Not later than January 1,  
4 2010, the Secretary shall develop a methodology, in  
5 consultation with primary care physician organiza-  
6 tions, the Medicare Payment Advisory Commission,  
7 and other experts, to increase payments under this  
8 section for designated evaluation and management  
9 services provided by primary and principal care phy-  
10 sicians through 1 or more of the following:

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

13           “(B) Service-specific bonus payments.

14           “(C) Any other methodology determined  
15 appropriate by the Secretary.

16           “(2) INCLUSION OF PROPOSED CRITERIA.—The  
17 methodology developed under paragraph (1) shall in-  
18 clude proposed criteria for physicians to qualify for  
19 such increased payments, including consideration  
20 of—

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

22           “(B) the specialty of the physician pro-  
23 viding the service; and

24           “(C) demonstration by the physician of  
25 voluntary participation in programs to improve

1 quality, such as participation in the Physician  
2 Quality Reporting Initiative (as determined by  
3 the Secretary) or practice-level qualification as  
4 a patient-centered medical home.

5 “(3) FUNDING.—

6 “(A) DETERMINATION.—The Secretary  
7 shall determine the aggregate estimated savings  
8 for a calendar year as a result of such increased  
9 payments on reducing preventable hospital ad-  
10 missions, duplicate testing, medication errors  
11 and drug interactions, Intensive Care Unit ad-  
12 missions, per capita health care expenditures,  
13 and other savings under this part and part A  
14 (including any savings with respect to items  
15 and services for which payment is not made  
16 under this section).

17 “(B) FUNDING.—The aggregate amount  
18 available for such increased payments during a  
19 calendar year shall be equal to the aggregate  
20 estimated savings (as determined under sub-  
21 paragraph (A)) for the calendar year (as deter-  
22 mined by the Secretary).

23 “(C) ADDITIONAL FUNDING AS DETER-  
24 MINED NECESSARY BY THE SECRETARY.—In  
25 addition to any funding made available under

1           subparagraph (B), there shall also be available  
2           to the Secretary, for purposes of effectively im-  
3           plementing this subsection, such additional  
4           funds as the Secretary determines are nec-  
5           essary.”.

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

9   **SEC. 304. ADDITIONAL INCENTIVE PAYMENT PROGRAM**  
10                   **FOR PRIMARY CARE SERVICES FURNISHED**  
11                   **IN HEALTH PROFESSIONAL SHORTAGE**  
12                   **AREAS.**

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

16           “(v) ADDITIONAL INCENTIVE PAYMENTS FOR PRI-  
17 MARY CARE SERVICES FURNISHED IN HEALTH PROFES-  
18 SIONAL SHORTAGE AREAS.—

19           “(1) IN GENERAL.—In the case of primary care  
20 services furnished on or after January 1, 2009, by  
21 a primary care physician in an area that is des-  
22 ignated (under section 332(a)(1)(A) of the Public  
23 Health Service Act) as a health professional short-  
24 age area as identified by the Secretary prior to the  
25 beginning of the year involved, in addition to the

1 amount of payment that would otherwise be made  
2 for such services under this part, there also shall be  
3 paid (on a monthly or quarterly basis) an amount  
4 equal to 10 percent of the payment amount for the  
5 service under this part.

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

7 “(A) PRIMARY CARE PHYSICIAN.—The  
8 term ‘primary care physician’ means a physi-  
9 cian (as described in section 1861(r)(1)) for  
10 whom primary care services accounted for at  
11 least a specified percent (as determined by the  
12 Secretary) of the allowed charges under this  
13 part for such physician in a prior period as de-  
14 termined appropriate by the Secretary.

15 “(B) PRIMARY CARE SERVICES.—The term  
16 ‘primary care services’ means procedure codes  
17 for services in the category of the Healthcare  
18 Common Procedure Coding System, as estab-  
19 lished by the Secretary under section  
20 1848(c)(5) (as of December 31, 2008 and as  
21 subsequently modified by the Secretary) con-  
22 sisting of evaluation and management services,  
23 but limited to such procedure codes in the cat-  
24 egory of office or other outpatient services, and  
25 consisting of subcategories of such procedure

1 codes for services for both new and established  
2 patients.

3 “(3) JUDICIAL REVIEW.—There shall be no ad-  
4 ministrative or judicial review under section 1869,  
5 1878, or otherwise, respecting the identification of  
6 primary care physicians or primary care services  
7 under this subsection.”.

8 (b) CONFORMING AMENDMENT.—Section  
9 1834(g)(2)(B) of the Social Security Act (42 U.S.C.  
10 1395m(g)(2)(B)) is amended by adding at the end the fol-  
11 lowing sentence: “Section 1833(v) shall not be taken into  
12 account in determining the amounts that would otherwise  
13 be paid pursuant to the preceding sentence.”.

14 **SEC. 305. PERMANENT EXTENSION OF FLOOR ON MEDI-**  
15 **CARE WORK GEOGRAPHIC ADJUSTMENT**  
16 **UNDER THE MEDICARE PHYSICIAN FEE**  
17 **SCHEDULE.**

18 Section 1848(e)(1)(E) of the Social Security Act (42  
19 U.S.C. 1395w-4(e)(1)(E)), as amended by section 134 of  
20 the Medicare Improvements for Patients and Providers  
21 Act of 2008 (Public Law 110-275), is amended by strik-  
22 ing “and before January 1, 2010,”.

1 **SEC. 306. PERMANENT EXTENSION OF MEDICARE INCEN-**  
2 **TIVE PAYMENT PROGRAM FOR PHYSICIAN**  
3 **SCARCITY AREAS.**

4 Section 1833(u) of the Social Security Act (42 U.S.C.  
5 1395l(u)), as amended by section 102 of the Medicare,  
6 Medicaid, and SCHIP Extension Act of 2007 (Public Law  
7 110–173), is amended—

8 (1) in paragraph (1)—

9 (A) by striking “, and before July 1,  
10 2008”; and

11 (B) by inserting “(or, in the case of serv-  
12 ices furnished on or after July 1, 2008, 10 per-  
13 cent)” after “5 percent”; and

14 (2) in paragraph (4)(D), by striking “before  
15 July 1, 2008” and inserting “before January 1,  
16 2010”.

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

20 (a) STUDY.—The Secretary shall conduct a study on  
21 the process used by the Secretary for determining relative  
22 value under the Medicare physician fee schedule under  
23 section 1848(c) of the Social Security Act (42 U.S.C.  
24 1395w–4(c)). Such study shall include an analysis of the  
25 following:

1           (1)(A) Whether the existing process includes  
2 equitable representation of primary care physicians  
3 (as defined in section 3(a)(4)); and

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

6           (2)(A) Whether the existing process provides  
7 the Secretary with expert and impartial input from  
8 physicians in medical specialties that provide pri-  
9 mary care to patients with multiple chronic diseases,  
10 the fastest growing part of the Medicare population;  
11 and

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

14           (3)(A) Whether the existing process includes  
15 equitable representation of physician medical special-  
16 ties in proportion to their relative contributions to-  
17 ward caring for Medicare beneficiaries, as deter-  
18 mined by the percentage of Medicare billings per  
19 specialty, percentage of Medicare encounters by spe-  
20 cialty, or such other measures of relative contribu-  
21 tions to patient care as determined by the Secretary;  
22 and

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



1 (b) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to services furnished on or after  
3 January 1, 2009.

4 **SEC. 312. ELIMINATION OF COST-SHARING FOR PREVEN-**  
5 **TIVE BENEFITS UNDER THE MEDICARE PRO-**  
6 **GRAM.**

7 (a) DEFINITION OF PREVENTIVE SERVICES.—Sec-  
8 tion 1861(ddd) of the Social Security Act, as added by  
9 section 101 of the Medicare Improvements for Patients  
10 and Providers Act of 2008 (Public Law 110–275), is  
11 amended—

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

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

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

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

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

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

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

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

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

8           “(F) An initial preventive physical examination  
9 (as defined in subsection (ww)).

10          “(G) Cardiovascular screening blood tests (as  
11 defined in subsection (xx)(1)).

12          “(H) Diabetes screening tests (as defined in  
13 subsection (yy)).

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

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

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

23          “(L) Screening mammography (as defined in  
24 subsection (jj)).

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

3           “(N) Bone mass measurement (as defined in  
4 subsection (rr)).

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

7 (b) COINSURANCE.—

8           (1) GENERAL APPLICATION.—

9           (A) IN GENERAL.—Section 1833(a)(1) of  
10 the Social Security Act (42 U.S.C.  
11 1395l(a)(1)), as amended by section 101 of the  
12 Medicare Improvements for Patients and Pro-  
13 viders Act of 2008 (Public Law 110–275) and  
14 section 202, is amended—

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

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

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

20 and

21           (iv) by inserting before the semicolon  
22 at the end the following: “, and (Y) with  
23 respect to preventive services described in  
24 subparagraphs (A) through (O) of section  
25 1861(ddd)(1), the amount paid shall be

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

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

9           (A) in paragraph (2)—

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

16           (ii) in subparagraph (C)—

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

18           (II) in clause (i)—

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

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

1 such clauses 2 ems to the left;  
2 and

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

7 (B) in paragraph (3)—

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

14 (ii) in subparagraph (C)—

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

16 (II) in clause (i)—

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

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

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

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

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

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

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

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

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

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

20 (c) WAIVER OF APPLICATION OF DEDUCTIBLE.—The  
21 first sentence of section 1833(b) of the Social Security Act  
22 (42 U.S.C. 1395l(b)), as amended by section 101 of the  
23 Medicare Improvements for Patients and Providers Act of  
24 2008 (Public Law 110–275), is amended—

1 (1) in clause (1), by striking “items and serv-  
2 ices described in section 1861(s)(10)(A)” and insert-  
3 ing “preventive services (as defined in section  
4 1861(ddd)(3))”;

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

6 (3) by striking subparagraphs (5) through (9).

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

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

13 (1) ways to assist primary care physicians (as  
14 defined in section 3(a)(4)) in—

15 (A) furnishing appropriate preventive serv-  
16 ices (as defined in section 1861(ddd)(3) of the  
17 Social Security Act, as added by section 212) to  
18 individuals enrolled under part B of title XVIII  
19 of such Act; and

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

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

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

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

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

## 14 **Subtitle C—Other Provisions**

### 15 **SEC. 321. HHS STUDY AND REPORT ON IMPROVING THE** 16 **ABILITY OF PHYSICIANS TO ASSIST MEDI-** 17 **CARE BENEFICIARIES IN OBTAINING NEEDED** 18 **PRESCRIPTIONS UNDER MEDICARE PART D.**

19 (a) STUDY.—The Secretary, in consultation with phy-  
20 sician organizations and other appropriate stakeholders,  
21 shall conduct a study on the development and implementa-  
22 tion of mechanisms to facilitate increased efficiency relat-  
23 ing to the physician’s role in Medicare beneficiaries obtain-  
24 ing needed prescription drugs under the Medicare pre-  
25 scription drug program under part D of title XVIII of the

1 Social Security Act. Such study shall include an analysis  
2 of ways to—

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

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

9 (3) recognize the physician work involved in the  
10 prescribing process, especially work that may extend  
11 beyond the amount considered to be bundled into  
12 payment for evaluation and management services.

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

19 **SEC. 322. QUALITY IMPROVEMENT ORGANIZATION ASSIST-**  
20 **ANCE FOR PHYSICIAN PRACTICES SEEKING**  
21 **TO BE PATIENT-CENTERED MEDICAL HOME**  
22 **PRACTICES.**

23 Not later than 90 days after the date of enactment  
24 of this Act, the Secretary shall revise the 9th Statement  
25 of Work under the Quality Improvement Program to in-

1 clude a requirement that, in order to be an eligible Quality  
2 Improvement Organization (in this section referred to as  
3 a “QIO”) for the 9th Statement of Work contract cycle,  
4 a QIO shall provide assistance, including technical assist-  
5 ance, to physicians under the Medicare program under  
6 title XVIII of the Social Security Act that seek to acquire  
7 the elements necessary to be recognized as a patient-cen-  
8 tered medical home practice under the National Com-  
9 mittee for Quality Assurance’s Physician Practice Connec-  
10 tions-PCMH module (or any successor module issued by  
11 such Committee).

12 **SEC. 323. HHS STUDY AND REPORT ON IMPROVED PATIENT**  
13 **CARE THROUGH INCREASED CAREGIVER AND**  
14 **PHYSICIAN INTERACTION.**

15 (a) STUDY.—The Secretary, in consultation with ap-  
16 propriate stakeholders, shall conduct a study on the devel-  
17 opment and implementation of mechanisms to promote  
18 and increase interaction between physicians and the fami-  
19 lies of Medicare beneficiaries, as well as other caregivers  
20 who support such beneficiaries, for the purpose of improv-  
21 ing patient care under the Medicare program. Such study  
22 shall include an analysis of—

23 (1) ways to recognize the physician work in-  
24 volved in discussing clinical issues with caregivers  
25 that relate to the care of the beneficiary; and

1           (2) regulations under the Medicare program  
2           that are barriers to interactions between physicians  
3           and caregivers and how such regulations should be  
4           revised to eliminate such barriers.

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

11 **SEC. 324. IMPROVED PATIENT CARE THROUGH EXPANDED**  
12                           **SUPPORT FOR LIMITED ENGLISH PRO-**  
13                           **FICIENCY SERVICES.**

14          (a) ADDITIONAL PAYMENTS FOR PHYSICIANS.—Sec-  
15          tion 1833 of the Social Security Act (42 U.S.C. 1395l),  
16          as amended by section 204, is amended by adding at the  
17          end the following new subsection:

18           “(w) ADDITIONAL PAYMENTS FOR PROVIDING SERV-  
19          ICES TO INDIVIDUALS WITH LIMITED ENGLISH PRO-  
20          FICIENCY.—

21           “(1) IN GENERAL.—In the case of physicians’  
22          services furnished on or after January 1, 2010 to an  
23          individual with limited English proficiency by a phy-  
24          sician, in addition to the amount of payment that  
25          would otherwise be made for such services under this

1 part, there shall also be paid an appropriate amount  
2 (as determined by the Secretary) in order to recog-  
3 nize the additional time involved in furnishing the  
4 service to such individual.

5 “(2) JUDICIAL REVIEW.—There shall be no ad-  
6 ministrative or judicial review under section 1869,  
7 1878, or otherwise, respecting the determination of  
8 the amount of additional payment under this sub-  
9 section.”.

10 (b) NATIONAL CLEARINGHOUSE.—Not later than  
11 180 days after the date of enactment of this Act, the Sec-  
12 retary shall establish a national clearinghouse to make  
13 available to the providers, patients, and States translated  
14 documents regarding patient care and education under the  
15 Medicare program, the Medicaid program, and the State  
16 Children’s Health Insurance Program under titles XVIII,  
17 XIX, and XXI, respectively, of the Social Security Act.

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

20 (1) AUTHORITY TO AWARD GRANTS.—The Sec-  
21 retary shall award grants to support language trans-  
22 lation services for primary care practices in medi-  
23 cally underserved areas (as defined in section 3(c)).

24 (2) AUTHORIZATION OF APPROPRIATIONS.—  
25 There are authorized to be appropriated to the Sec-

1       retary to award grants under this subsection, such  
2       sums as are necessary for fiscal years beginning with  
3       fiscal year 2009.

4       **SEC. 325. HHS STUDY AND REPORT ON USE OF REAL-TIME**  
5                                   **MEDICARE CLAIMS ADJUDICATION.**

6       (a) STUDY.—The Secretary of Health and Human  
7       Services (in this subsection referred to as the “Secretary”)  
8       shall conduct a study to assess the ability of the Medicare  
9       program under title XVIII of the Social Security Act to  
10      engage in real-time claims adjudication for items and serv-  
11      ices furnished to Medicare beneficiaries.

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

16      (c) REPORT.—Not later than January 1, 2010, the  
17      Secretary shall submit to Congress a report containing the  
18      results of the study conducted under subsection (a), to-  
19      gether with recommendations for such legislation and ad-  
20      ministrative action as the Secretary determines appro-  
21      priate.



1 force data from the Health Resources and Services Admin-  
2 istration, the Council on Graduate Medical Education, the  
3 Association of American Medical Colleges, and input from  
4 physician membership organizations that represent pri-  
5 mary care physicians.

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

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

14 (b) REPORT.—

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

24 (2) ADDITIONAL REPORTS.—The Comptroller  
25 General may periodically prepare and release as nec-

