

111TH CONGRESS
1ST SESSION

H. R. 3109

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

IN THE HOUSE OF REPRESENTATIVES

JUNE 26, 2009

Mr. TEAGUE (for himself, Mr. GENE GREEN of Texas, Mr. SPACE, and Mr. GONZALEZ) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Veterans' Affairs, Education and Labor, Armed Services, and Natural Resources, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

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

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

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

2 (a) SHORT TITLE.—This Act may be cited as the
 3 “Health Access and Health Professions Supply Act of
 4 2009” or “HAHPSA 2009”.

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

Sec. 1. Short title; table of contents.

Sec. 2. Findings.

TITLE I—AMENDMENTS TO THE SOCIAL SECURITY ACT

Subtitle A—Workforce Improvements

Sec. 101. National health care workforce commission.

Sec. 102. State health workforce centers program.

Sec. 103. Improvements to payments for graduate medical education under
 medicare.

Sec. 104. Distribution of resident trainees in an emergency.

Sec. 105. Authority to include costs of training of psychologists in payments to
 hospitals for approved educational activities under Medicare.

**Subtitle B—Geriatric Assessments and Chronic Care Management and
 Coordination Services Under the Medicare Program**

Sec. 111. Medicare coverage of geriatric assessments.

Sec. 112. Medicare coverage of chronic care management and coordination serv-
 ices.

Sec. 113. Outreach activities regarding geriatric assessments and chronic care
 management and coordination services under the Medicare pro-
 gram.

Sec. 114. Utilization of telehealth services to furnish geriatric assessments and
 chronic care management and coordination services under the
 Medicare program.

Sec. 115. Study and report on geriatric assessments and chronic care manage-
 ment and coordination services under the Medicare program.

Sec. 116. Rule of construction.

TITLE II—AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT

Sec. 201. Expansion of National Health Service Corps programs.

Sec. 202. National health service corps scholarship program for medical, dental,
 physician assistant, pharmacy, behavioral and mental health,
 public health, and nursing students in the United States public
 health sciences track in affiliated schools.

Sec. 203. Federal medical facility grant program and program assessments.

Sec. 204. Health professions training loan program.

Sec. 205. United States Public Health Sciences Track.

Sec. 206. Medical education debt reimbursement for physicians of the Veterans
 Health Administration.

Sec. 207. Promoting education and training of psychologists to provide mental and behavioral health services to underserved populations.

TITLE III—HEALTH PROFESSIONAL TRAINING PIPELINE
PARTNERSHIPS PROGRAM

Sec. 301. Grants to prepare students for careers in health care.

1 SEC. 2. FINDINGS.

2 (a) FINDINGS RELATED TO HEALTH CARE ACCESS
3 IN RURAL, FRONTIER, AND URBAN UNDERSERVED
4 AREAS OF THE UNITED STATES.—Congress finds the fol-
5 lowing:

6 (1) The United States does not have a cohesive
7 or coordinated approach to addressing health work-
8 force shortages and problems with reliable access to
9 quality, affordable health care.

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

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

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

21 (5) Individuals over 65 years of age have twice
22 as many doctor visits as those individuals under 65

1 years of age, resulting in an increase in the demand
2 for physicians, physician assistants, pharmacists be-
3 havioral and mental health professionals, nurses,
4 and dentists.

5 (6) The rates of chronic diseases (such as dia-
6 betes) are increasing in the population of the United
7 States.

8 (7) There are 47,000,000 citizens of the United
9 States who do not have health insurance, and over
10 130,000,000 individuals within the United States
11 who do not have dental insurance. Those individuals
12 who are uninsured have limited access to health
13 care.

14 (8) Academic health centers, Federal medical
15 facilities, and teaching hospitals provide a substan-
16 tial percentage of safety net services in the United
17 States to uninsured and underinsured populations
18 and to those individuals who have 1 or more chronic
19 diseases. Such centers, facilities, and teaching hos-
20 pitals provide those safety net services while concur-
21 rently providing for the training of health profes-
22 sionals.

23 (9) The pipeline for the education of health pro-
24 fessionals—

25 (A) begins and often ends in urban areas;

1 (B) does not reliably include Federal sup-
2 port for nonphysician training;

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

6 (D) discourages interdisciplinary, team,
7 and care coordination models as a result of re-
8 strictive regulations.

9 (10) Health reform must include measures to
10 transform the health delivery system to assure ac-
11 cess, quality, and efficiency by utilizing contem-
12 porary models and venues of care.

13 (11) Reform of the health delivery system will
14 require modernization of the training of health pro-
15 fessionals to ensure that health professionals—

16 (A) practice in integrated teams in a vari-
17 ety of delivery venues (including inpatient and
18 ambulatory settings and long-term care facili-
19 ties) to utilize decision support and health in-
20 formation systems;

21 (B) deliver patient-centered care;

22 (C) practice evidence-based health care;

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

1 (E) deliver culturally appropriate, person-
2 alized care.

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

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

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

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

14 (4) Rural counties have less than half the num-
15 ber of dentists per capita compared to large metro-
16 politan areas (29 versus 62 for population of
17 100,000).

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

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

22 (7) The number of dental school graduates in
23 the United States decreased by 20 percent between
24 1982 and 2003 and the average age of practicing
25 dentists in the United States is 49.

1 (8) There were over 400 dental faculty vacan-
2 cies in the school year beginning in 2006.

3 (9) In 2007, the average debt of a dental stu-
4 dent at graduation was \$172,627.

5 (c) FINDINGS RELATED TO PHYSICIAN SHORTAGES,
6 EDUCATION, AND DISTRIBUTION.—Congress finds the fol-
7 lowing:

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

10 (2) Although 21 percent of the population of
11 the United States lives in rural areas, only 10 per-
12 cent of physicians work in rural areas and, for every
13 1 physician who goes into practice in regions with a
14 low supply of physicians, 4 physicians go into prac-
15 tice in regions with a high supply of physicians.

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

23 (4) In order to respond to forecasted shortages,
24 experts have recommended an increase between 15

1 and 30 percent in class size at medical schools over
2 the next 10 years.

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

7 (6) The number of graduates from medical
8 school in the United States who choose to practice
9 family medicine has plummeted 50 percent in less
10 than 10 years. Without congressional intervention,
11 such decline will likely continue, and access to care
12 in underserved areas will rapidly deteriorate. Family
13 physicians represent 58 percent of the rural physi-
14 cian workforce, 70 percent of non-Federal physicians
15 in whole-county health professional shortage areas,
16 and 78 percent of primary care physician full-time
17 equivalents in the National Health Service Corps.

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

21 (8) Funding for medical education which is pro-
22 vided through direct Graduate Medical Education
23 (GME) and Indirect Medical Education (IME)
24 under the Medicare program is not transparent or
25 accountable, nor is it aligned to the types of health

1 professionals most needed or to the areas in which
2 health professionals are most needed.

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

6 (10) The Council on Graduate Medical Edu-
7 cation's 18th Report (issued in 2007), entitled "New
8 Paradigms for Physician Training for Improving Ac-
9 cess to Health Care", and 19th Report (issued in
10 2007), entitled "Enhancing Flexibility in Graduate
11 Medical Education", each call for changes to address
12 the healthcare needs of the United States by remov-
13 ing barriers to expanding and more appropriately
14 training the physician workforce.

15 (d) FINDINGS RELATED TO NURSING SHORTAGES,
16 EDUCATION, AND DISTRIBUTION.—Congress finds the fol-
17 lowing:

18 (1) By 2020, nursing shortages are forecast to
19 be in the range of 300,000 to 1,000,000 and the
20 Bureau of Labor Statistics of the Department of
21 Labor estimates that more than 1,200,000 new and
22 replacement registered nurses will be needed by
23 2014.

24 (2) Nurse vacancy rates are currently 8 percent
25 or greater in hospitals and community health centers

1 receiving assistance under section 330 of the Public
2 Health Service Act, and for nursing faculty posi-
3 tions.

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

8 (4) Nursing baccalaureate and graduate pro-
9 grams rejected more than 40,000 qualified nursing
10 school applicants in 2006, with faculty shortages
11 identified by such programs as a major reason for
12 turning away qualified applicants.

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

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

20 (7) The average age of nurses in the United
21 States is 49 and the average age of an associate pro-
22 fessor nurse faculty member in the United States is
23 56.

24 (8) Geriatric patients receiving care from
25 nurses trained in geriatrics are less frequently re-

1 admitted to hospitals or transferred from skilled
2 nursing facilities and nursing facilities to hospitals.

3 (e) FINDINGS RELATED TO PUBLIC HEALTH WORK-
4 FORCE SHORTAGES.—Congress finds the following:

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

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

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

16 (4) Approximately 20 percent of local health de-
17 partment employees will be eligible for retirement by
18 2010.

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

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

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

1 (1) The purpose of the physician assistant pro-
2 fession is to extend the ability of physicians to pro-
3 vide primary care services, particularly in rural and
4 other medically underserved communities.

5 (2) Physician assistants always practice medi-
6 cine as a team with their supervising physicians,
7 however, supervising physicians need not be phys-
8 ically present when physician assistants provide
9 medical care.

10 (3) Physician assistants are legally regulated in
11 all States, the District of Columbia, and Guam. All
12 States, the District of Columbia, and Guam author-
13 ize physicians to delegate prescriptive authority to
14 physician assistants.

15 (4) In 2007, physician assistants made approxi-
16 mately 245,000,000 patient visits and prescribed or
17 recommended approximately 303,000,000 medica-
18 tions.

19 (5) The National Association of Community
20 Health Centers, the George Washington University,
21 and the Robert Graham Center for Policy Studies in
22 Family Medicine and Primary Care found that while
23 the number of patients who seek care at community
24 health centers has increased, the number of primary
25 care providers, including physician assistants, has

1 not. The report estimates a need for 15,500 primary
2 health care providers to provide care at community
3 health centers.

4 (g) FINDINGS RELATED TO MENTAL HEALTH PRO-
5 FESSIONAL SHORTAGES.—Congress finds the following:

6 (1) The National Institute of Mental Health es-
7 timates that 26.2 percent of citizens of the United
8 States ages 18 and older suffer from a diagnosable
9 mental disorder. Approximately 20 percent of chil-
10 dren in the United States have diagnosable mental
11 disorders with at least mild functional impairment.

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

18 (3) According to the Department of Health and
19 Human Services, minority representation is lacking
20 in the mental health workforce. Although 12 percent
21 of the population of the United States is African-
22 American, only 2 percent of psychologists, 2 percent
23 of psychiatrists, and 4 percent of social workers are
24 African-American. Moreover, there are only 29 men-
25 tal health professionals who are Hispanic for every

1 100,000 individuals who are Hispanic in the United
2 States, compared with 173 non-Hispanic White pro-
3 viders for every 100,000 individuals who are non-
4 Hispanic White in the United States.

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

7 (1) In 2006, the National Health Service Corps
8 had a total of 4,200 vacant positions in health pro-
9 fessional shortage areas, but only 1,200 of those po-
10 sitions were funded. For each National Health Serv-
11 ice Corps award, there are 7 applicants.

12 (2) Community health centers receiving assist-
13 ance under section 330 of the Public Health Service
14 Act have expanded to serve 16,000,000 individuals
15 in over 1,000 sites. Such community health centers
16 have high vacancy rates for family physicians (13
17 percent), obstetricians and gynecologists (21 per-
18 cent), dentists, nurses, and other health profes-
19 sionals.

20 (3) The Institute of Medicine of the National
21 Academies has recommended that medical education
22 and public health issues be more closely aligned, es-
23 pecially in relation to preparedness for natural disas-
24 ters, pandemic, bioterrorism, and other threats to
25 public health.

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

7 (5) There is some duplication, and little coordi-
8 nation, between the Council on Graduate Medical
9 Education (related to the physician workforce), the
10 National Advisory Committee on Nursing Programs
11 (related to the nursing workforce), the Advisory
12 Committee on Training in Primary Care Medicine
13 and Dentistry, and other advisory committees and
14 councils.

15 (6) The Association of Academic Health Cen-
16 ters calls for making the health workforce of the
17 United States a priority domestic policy issue and
18 creating a national health workforce planning body
19 that engages Federal, State, public, and private
20 stakeholders.

1 **TITLE I—AMENDMENTS TO THE**
2 **SOCIAL SECURITY ACT**
3 **Subtitle A—Workforce**
4 **Improvements**

5 **SEC. 101. NATIONAL HEALTH CARE WORKFORCE COMMIS-**
6 **SION.**

7 (a) PURPOSE.—It is the purpose of this section to
8 establish a National Health Care Workforce Commission
9 that—

10 (1) serves as a national resource for Congress,
11 the President, States, and localities by—

12 (A) disseminating information on current
13 and projected health care workforce supply and
14 demand;

15 (B) disseminating information on health
16 care workforce education and training capacity
17 and instruction or delivery models and best
18 practices;

19 (C) recognizing efforts of Federal, State,
20 and local partnerships to develop and offer
21 health care career pathways of proven effective-
22 ness;

23 (D) disseminating information on prom-
24 ising retention practices for health care profes-
25 sionals;

1 (E) communicating information on impor-
2 tant policies and practices that affect the re-
3 cruitment, education and training, and reten-
4 tion of the health care workforce; and

5 (F) disseminating recommendations on the
6 development of a fiscally sustainable integrated
7 workforce that supports a high-quality health
8 care delivery system that meets the needs of pa-
9 tients and populations;

10 (2) communicates and coordinates with the De-
11 partments of Health and Human Services, Labor,
12 and Education on related activities administered by
13 one or more of such Departments;

14 (3) develops and commissions evaluations of
15 education and training activities to determine wheth-
16 er the demand for health care workers is being met;

17 (4) identifies barriers to improved coordination
18 at the Federal, State, and local levels and rec-
19 ommend ways to address such barriers; and

20 (5) encourages innovations to address popu-
21 lation needs, constant changes in technology, and
22 other environmental factors.

23 (b) ESTABLISHMENT.—There is hereby established
24 the National Health Care Workforce Commission (in this
25 section referred to as the “Commission”).

1 (c) MEMBERSHIP.—

2 (1) NUMBER AND APPOINTMENT.—The Com-
3 mission shall be composed of 15 members to be ap-
4 pointed by the Comptroller General.

5 (2) QUALIFICATIONS.—

6 (A) IN GENERAL.—The membership of the
7 Commission shall include individuals—

8 (i) with national recognition for their
9 expertise in health care labor market anal-
10 ysis, including health care workforce anal-
11 ysis; health care finance and economics;
12 health care facility management; health
13 care plans and integrated delivery systems;
14 health care workforce education and train-
15 ing; health care philanthropy; providers of
16 health care services; and other related
17 fields; and

18 (ii) who will provide a combination of
19 professional perspectives, broad geographic
20 representation, and a balance between
21 urban, suburban, and rural representa-
22 tives.

23 (B) INCLUSION.—

1 (i) IN GENERAL.—The membership of
2 the Commission shall include no less than
3 one representative of—

4 (I) the health care workforce and
5 health professionals;

6 (II) employers;

7 (III) third-party payers;

8 (IV) individuals skilled in the
9 conduct and interpretation of health
10 care services and health economics re-
11 search;

12 (V) representatives of consumers;

13 (VI) labor unions;

14 (VII) State or local workforce in-
15 vestment boards; and

16 (VIII) educational institutions
17 (which may include elementary and
18 secondary institutions, institutions of
19 higher education, including 2 and 4
20 year institutions, or registered ap-
21 prenticeship programs).

22 (ii) ADDITIONAL MEMBERS.—The re-
23 maining membership may include addi-
24 tional representatives from clause (i) and
25 other individuals as determined appro-

1 priate by the Comptroller General of the
2 United States.

3 (C) MAJORITY NON-PROVIDERS.—Individ-
4 uals who are directly involved in health profes-
5 sions education or practice shall not constitute
6 a majority of the membership of the Commis-
7 sion.

8 (3) TERMS.—

9 (A) IN GENERAL.—The terms of members
10 of the Commission shall be for 3 years except
11 that the Comptroller General shall designate
12 staggered terms for the members first ap-
13 pointed.

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

23 (4) COMPENSATION.—While serving on the
24 business of the Commission (including travel time),
25 a member of the Commission shall be entitled to

1 compensation at the per diem equivalent of the rate
2 provided for level IV of the Executive Schedule
3 under section 5315 of title 5, United States Code,
4 and while so serving away from home and the mem-
5 ber's regular place of business, a member may be al-
6 lowed travel expenses, as authorized by the Chair-
7 man of the Commission. Physicians serving as per-
8 sonnel of the Commission may be provided a physi-
9 cian comparability allowance by the Commission in
10 the same manner as Government physicians may be
11 provided such an allowance by an agency under sec-
12 tion 5948 of title 5, United States Code, and for
13 such purpose subsection (i) of such section shall
14 apply to the Commission in the same manner as it
15 applies to the Tennessee Valley Authority. For pur-
16 poses of pay (other than pay of members of the
17 Commission) and employment benefits, rights, and
18 privileges, all personnel of the Commission shall be
19 treated as if they were employees of the United
20 States Senate.

21 (5) CHAIRMAN, VICE CHAIRMAN.—The members
22 of the Commission shall elect, by a majority vote, a
23 chairman and vice chairman of the Commission for
24 the term of their appointment or portion remaining.
25 Such elections shall occur at the end of any chair-

1 man or vice chairman's term or upon the resignation
2 of the chairman or vice chairman from the Commis-
3 sion.

4 (6) MEETINGS.—The Commission shall meet at
5 the call of the chairman, but no less frequently than
6 on a quarterly basis.

7 (d) DUTIES.—

8 (1) REVIEW OF HEALTH CARE WORKFORCE
9 AND ANNUAL REPORTS.—In order to develop a fis-
10 cally sustainable integrated workforce that supports
11 a high-quality, readily accessible health care delivery
12 system that meets the needs of patients and popu-
13 lations, the Commission, in consultation with rel-
14 evant Federal, State, and local agencies, shall—

15 (A) review current and projected health
16 care workforce supply and demand, including
17 the topics described in paragraph (2);

18 (B) make recommendations to Congress
19 and the Administration concerning national
20 health care workforce priorities, goals, and poli-
21 cies;

22 (C) by not later than October 1 of each
23 year (beginning with 2011), submit a report to
24 Congress and the Administration containing the

1 results of such reviews and recommendations
2 concerning related policies; and

3 (D) by not later than April 1 of each year
4 (beginning with 2011), submit a report to Con-
5 gress and the Administration containing a re-
6 view of, and recommendations on, at a min-
7 imum one high priority area as described in
8 paragraph (3).

9 (2) SPECIFIC TOPICS TO BE REVIEWED.—The
10 topics described in this paragraph include—

11 (A) current health care workforce supply
12 and distribution, including demographics, skill
13 sets, and demands, with projected demands
14 during the subsequent 10 and 25 year periods;

15 (B) health care workforce education and
16 training capacity, including the number of stu-
17 dents who have completed education and train-
18 ing, including registered apprenticeships; the
19 number of qualified faculty; the education and
20 training infrastructure; and the education and
21 training demands, with projected demands dur-
22 ing the subsequent 10 and 25 year periods, and
23 including identified models of education and
24 training delivery and best practices;

1 (C) the implications of new and existing
2 Federal policies which affect the health care
3 workforce, including Medicare and Medicaid
4 graduate medical education policies, titles VII
5 and VIII of the Public Health Service Act (42
6 U.S.C. 292 et seq. and 296 et seq.), the Na-
7 tional Health Service Corps (with recommenda-
8 tions for aligning such programs with national
9 health workforce priorities and goals), and
10 other health care workforce programs, including
11 those supported through the Workforce Invest-
12 ment Act of 1998 (29 U.S.C. 2801 et seq.), the
13 Carl D. Perkins Career and Technical Edu-
14 cation Act of 2006 (20 U.S.C. 2301 et seq.),
15 the Higher Education Act of 1965 (20 U.S.C.
16 1001 et seq.), and any other Federal health
17 care workforce programs; and

18 (D) the health care workforce needs of spe-
19 cial populations, such as minorities, rural popu-
20 lations, medically underserved populations, gen-
21 der specific needs, and geriatric and pediatric
22 populations with recommendations for new and
23 existing Federal policies to meet the needs of
24 these special populations.

25 (3) HIGH PRIORITY AREAS.—

1 (A) IN GENERAL.—The initial high priority
2 topics described in this paragraph include—

3 (i) integrated health care workforce
4 planning that identifies health care profes-
5 sional skills needed and maximizes the skill
6 sets of health care professionals across dis-
7 ciplines;

8 (ii) an analysis of the nature, scopes
9 of practice, and demands for health care
10 workers in the enhanced information tech-
11 nology and management workplace;

12 (iii) Medicare and Medicaid graduate
13 medical education policies and rec-
14 ommendations for aligning with national
15 workforce goals;

16 (iv) nursing workforce capacity at all
17 levels, including education and training ca-
18 pacity, projected demands, and integration
19 within the health care delivery system;

20 (v) oral health care workforce capac-
21 ity, including education and training ca-
22 pacity, projected demands, and integration
23 within the health care delivery system;

24 (vi) mental and behavioral health care
25 workforce capacity, including education

1 and training capacity, projected demands,
2 and integration within the health care de-
3 livery system;

4 (vii) allied health and public health
5 care workforce capacity, including edu-
6 cation and training capacity, projected de-
7 mands, and integration within the health
8 care delivery system; and

9 (viii) the geographic distribution of
10 health care providers as compared to the
11 identified health care workforce needs of
12 States and regions.

13 (B) FUTURE DETERMINATIONS.—The
14 Commission may require that additional topics
15 be included under subparagraph (A). The ap-
16 propriate committees of Congress may rec-
17 ommend to the Commission the inclusion of
18 other topics for health care workforce develop-
19 ment areas that require special attention.

20 (4) GRANT PROGRAM.—The Commission shall
21 oversee and report to Congress on the State Health
22 Care Workforce Development Grants program estab-
23 lished in section 412.

24 (5) STUDY.—The Commission shall study effec-
25 tive mechanisms for financing education and train-

1 ing for careers in health care, including public health
2 and allied health.

3 (6) RECOMMENDATIONS.—The Commission
4 shall submit recommendations to Congress, the De-
5 partment of Labor, and the Department of Health
6 and Human Services about improving safety, health,
7 and worker protections in the workplace for the
8 health care workforce.

9 (7) ASSESSMENT.—The Commission shall as-
10 sess and receive reports from the National Center
11 for Health Care Workforce Analysis established
12 under title VII of the Public Service Health Act.

13 (e) CONSULTATION WITH FEDERAL, STATE, AND
14 LOCAL AGENCIES, CONGRESS, AND OTHER ORGANIZA-
15 TIONS.—

16 (1) IN GENERAL.—The Commission shall con-
17 sult with Federal agencies (including the Depart-
18 ments of Health and Human Services, Labor, Edu-
19 cation, Commerce, Agriculture, Defense, and Vet-
20 erans Affairs and the Environmental Protections
21 Agency), Congress, the Medicare Payment Advisory
22 Commission, and, to the extent practicable, with
23 State and local agencies, voluntary health care orga-
24 nizations professional societies, and other relevant
25 public-private health care partnerships.

1 (2) OBTAINING OFFICIAL DATA.—The Commis-
2 sion, consistent with established privacy rules, may
3 secure directly from any department or agency of
4 the United States information necessary to enable
5 the Commission to carry out this section.

6 (3) DETAIL OF FEDERAL GOVERNMENT EM-
7 PLOYEES.—An employee of the Federal Government
8 may be detailed to the Commission without reim-
9 bursement. The detail of such an employee shall be
10 without interruption or loss of civil service status.

11 (f) DIRECTOR AND STAFF; EXPERTS AND CONSULT-
12 ANTS.—Subject to such review as the Comptroller General
13 of the United States determines to be necessary to ensure
14 the efficient administration of the Commission, the Com-
15 mission may—

16 (1) employ and fix the compensation of an execu-
17 tive director (subject to the approval of the Comp-
18 troller General) and such other personnel as may be
19 necessary to carry out its duties (without regard to
20 the provisions of title 5, United States Code, gov-
21 erning appointments in the competitive service);

22 (2) seek such assistance and support as may be
23 required in the performance of its duties from ap-
24 propriate Federal departments and agencies;

1 (3) enter into contracts or make other arrange-
2 ments, as may be necessary for the conduct of the
3 work of the Commission (without regard to section
4 3709 of the Revised Statutes (41 U.S.C. 5));

5 (4) make advance, progress, and other pay-
6 ments which relate to the work of the Commission;

7 (5) provide transportation and subsistence for
8 persons serving without compensation; and

9 (6) prescribe such rules and regulations as the
10 Commission determines to be necessary with respect
11 to the internal organization and operation of the
12 Commission.

13 (g) POWERS.—

14 (1) DATA COLLECTION.—In order to carry out
15 its functions under this section, the Commission
16 shall—

17 (A) utilize existing information, both pub-
18 lished and unpublished, where possible, collected
19 and assessed either by its own staff or under
20 other arrangements made in accordance with
21 this section, including coordination with the Bu-
22 reau of Labor Statistics;

23 (B) carry out, or award grants or con-
24 tracts for the carrying out of, original research

1 and development, where existing information is
2 inadequate, and

3 (C) adopt procedures allowing interested
4 parties to submit information for the Commis-
5 sion's use in making reports and recommenda-
6 tions.

7 (2) ACCESS OF THE GOVERNMENT ACCOUNT-
8 ABILITY OFFICE TO INFORMATION.—The Comp-
9 troller General of the United States shall have unre-
10 stricted access to all deliberations, records, and non-
11 proprietary data of the Commission, immediately
12 upon request.

13 (3) PERIODIC AUDIT.—The Commission shall
14 be subject to periodic audit by a third party ap-
15 pointed by the Secretary.

16 (h) AUTHORIZATION OF APPROPRIATIONS.—

17 (1) REQUEST FOR APPROPRIATIONS.—The
18 Commission shall submit requests for appropriations
19 in the same manner as the Comptroller General of
20 the United States submits requests for appropria-
21 tions. Amounts so appropriated for the Commission
22 shall be separate from amounts appropriated for the
23 Comptroller General.

1 (2) AUTHORIZATION.—There are authorized to
2 be appropriated such sums as may be necessary to
3 carry out this section.

4 (3) GIFTS.—The Commission is authorized to
5 accept and gifts for purposing of carrying out this
6 section.

7 (i) DEFINITIONS.—In this section:

8 (1) HEALTH CARE WORKFORCE.—The term
9 “health care workforce” includes all health care pro-
10 viders with direct patient care and support respon-
11 sibilities, including physicians, nurses, physician as-
12 sistants, pharmacists, oral healthcare professionals,
13 allied health professionals, mental health profes-
14 sionals, and public health professionals.

15 (2) HEALTH PROFESSIONALS.—The term
16 “health professionals” includes—

17 (A) dentists, dental hygienists, primary
18 care providers, specialty physicians, nurses,
19 nurse practitioners, physician assistants, psy-
20 chologists and other behavioral and mental
21 health professionals, social workers, physical
22 therapists, public health professionals, clinical
23 pharmacists, allied health professionals, chiro-
24 practors, community health workers, school
25 nurses, certified nurse midwives, podiatrists, li-

1 censed complementary and alternative medicine
2 providers, and integrative health practitioners;

3 (B) national representatives of health pro-
4 fessionals;

5 (C) representatives of schools of medicine,
6 osteopathy, nursing, allied health, educational
7 programs for public health professionals, behav-
8 ioral and mental health professionals (as so de-
9 fined), social workers, physical therapists, oral
10 health care industry dentistry and dental hy-
11 giene, and physician assistants;

12 (D) representatives of public and private
13 teaching hospitals, and ambulatory health facili-
14 ties, including Federal medical facilities; and

15 (E) any other health professional the
16 Comptroller General of the United States deter-
17 mines appropriate.

18 **SEC. 102. STATE HEALTH WORKFORCE CENTERS PROGRAM.**

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

1 (b) PARTICIPATING STATES.—A State seeking to
2 participate in the program shall submit an application to
3 the Secretary containing such information and at such
4 time as the Secretary may specify. The Secretary may only
5 consider under the preceding sentence 1 application sub-
6 mitted by each State which has been certified by the Gov-
7 ernor or the chief executive officer of the State.

8 (c) USE OF FUNDS.—Grants awarded under sub-
9 section (a) may be used to support activities designed to
10 improve the training, deployment, and retention of critical
11 health professionals in underserved areas and for under-
12 served populations, including the following:

13 (1) Conducting assessments of key health pro-
14 fessional capacity and needs. Such assessments shall
15 be conducted in a coordinated manner that provides
16 for the nationwide collection of health professional
17 data.

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

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

3 (d) FUNDING.—

4 (1) AUTHORIZATION OF APPROPRIATIONS.—

5 There are authorized to be appropriated
6 \$13,750,000 to carry out this section.

7 (2) MATCHING REQUIREMENT.—The Secretary
8 may require a State, in order to be eligible to receive
9 a grant under this section, to agree that, with re-
10 spect to the costs incurred by the State in carrying
11 out the activities for which the grant was awarded,
12 the State will make available (directly or through do-
13 nations from public or private entities) non-Federal
14 contributions in an amount equal to a percent of
15 Federal funds provided under the grant (as deter-
16 mined appropriate by the Secretary).

17 (e) DEFINITIONS.—In this section:

18 (1) SECRETARY.—The term “Secretary” means
19 the Secretary of Health and Human Services.

20 (2) STATE.—The term “State” means—

21 (A) a State;

22 (B) the District of Columbia;

23 (C) the Commonwealth of Puerto Rico;

24 and

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

3 **SEC. 103. IMPROVEMENTS TO PAYMENTS FOR GRADUATE**
 4 **MEDICAL EDUCATION UNDER MEDICARE.**

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

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

10 (A) in clause (i), by inserting “clause (iii)
 11 and” after “subject to”; and

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

14 “(iii) INCREASE IN CAPS ON GRAD-
 15 UATE MEDICAL EDUCATION POSITIONS FOR
 16 STATES WITH A SHORTAGE OF RESI-
 17 DENTS.—

18 “(I) IN GENERAL.—For cost re-
 19 porting periods beginning on or after
 20 January 1, 2011, the Secretary shall
 21 increase the otherwise applicable limit
 22 on the total number of full-time equiv-
 23 alent residents in the field of
 24 allopathic or osteopathic medicine de-
 25 termined under clause (i) with respect

1 to a qualifying hospital by an amount
2 equal to 15 percent of the amount of
3 the otherwise applicable limit (deter-
4 mined without regard to this clause).
5 Such increase shall be phased-in
6 equally over a period of 3 cost report-
7 ing periods beginning with the first
8 cost reporting period in which the in-
9 crease is applied under the previous
10 sentence to the hospital.

11 “(II) QUALIFYING HOSPITAL.—
12 In this clause, the term ‘qualifying
13 hospital’ means a hospital that agrees
14 to use the increase in the number of
15 full-time equivalent residents under
16 subclause (I) to support community-
17 based training which emphasizes un-
18 derserved areas and innovative train-
19 ing models which address community
20 needs and reflect emerging, evolving,
21 and contemporary models of health
22 care delivery. A qualifying hospital
23 shall give priority to providing such
24 training and training models to health
25 professionals in specialties which the

1 Secretary, in consultation with the
2 Permanent National Health Work-
3 force Commission established under
4 section 101(a) of the Health Access
5 and Health Professions Supply Act of
6 2009, determines are in high-need (in-
7 cluding family medicine, general sur-
8 gery, geriatrics, general internal medi-
9 cine, general surgery, and obstetrics
10 and gynecology).

11 “(III) INCREASE IN PAY-
12 MENTS.—Notwithstanding any other
13 provision of law, in the case of full-
14 time equivalent residents added to a
15 hospital’s training program as a result
16 of such increase, the Secretary shall
17 provide for an increase in the amounts
18 otherwise payable under this sub-
19 section with respect to direct graduate
20 medical education costs that would
21 otherwise apply with respect to such
22 residents by 10 percent. Such in-
23 creased payments shall be made to the
24 facility in which the training is pro-
25 vided to such residents.”.

1 (2) INDIRECT MEDICAL EDUCATION.—Section
2 1886(d)(5)(B) of the Social Security Act (42 U.S.C.
3 1395ww(d)(5)(B)) is amended by adding at the end
4 the following new clause:

5 “(x) Clause (iii) of subsection (h)(4)(F) shall
6 apply to clause (v) in the same manner and for the
7 same period as such clause (iii) applies to clause (i)
8 of such subsection.”.

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

11 (1) IN GENERAL.—The Secretary of Health and
12 Human Services (in this subsection referred to as
13 the “Secretary”) shall, by regulation, provide for the
14 use of payments for direct graduate medical edu-
15 cation costs under section 1886(h) of the Social Se-
16 curity Act (42 U.S.C. 1395ww(h)) and payments for
17 the indirect costs of medical education under section
18 1886(d)(5)(B) of the Social Security Act (42 U.S.C.
19 1395ww(d)(5)(B)) to support the implementation of
20 community-based training and innovative training
21 models under subsections (h)(4)(F)(iii)(II) and
22 (d)(5)(B)(x) of section 1886 of the Social Security
23 Act (42 U.S.C. 1395ww).

24 (2) USE OF MODEL OF CARE DELIVERY.—In
25 promulgating regulations under paragraph (1), the

1 Secretary shall consider the model of care delivery of
2 the Institute of Medicine of the National Academies.

3 (3) CONSULTATION.—In promulgating such
4 regulations, the Secretary shall consult with the Per-
5 manent National Health Workforce Commission es-
6 tablished under section 101(a).

7 (c) DETERMINATION OF HOSPITAL-SPECIFIC AP-
8 PROVED FTE RESIDENT AMOUNTS.—Section 1886(h)(2)
9 of the Social Security Act (42 U.S.C. 1395ww(h)(2)) is
10 amended by adding at the end the following new subpara-
11 graph:

12 “(G) FLEXIBILITY IN DETERMINATION.—
13 “(i) IN GENERAL.—Notwithstanding
14 the preceding provisions of this paragraph,
15 the approved FTE resident amount for
16 each cost reporting period beginning on or
17 after January 1, 2011, with respect to an
18 applicable resident shall be determined
19 using a methodology established by the
20 Secretary that allows flexibility for pay-
21 ments to be made for costs in addition to
22 the costs of hospital-sponsored education.
23 Such methodology shall provide that non-
24 teaching hospital-based entities (such as
25 managed care organizations and public and

1 private healthcare consortia) that are capa-
2 ble of assembling all of the resources nec-
3 essary for effectively providing graduate
4 medical education may receive payments
5 for providing graduate medical education,
6 either as the sponsor of such graduate
7 medical education program or as an affil-
8 iate of such a sponsor.

9 “(ii) APPLICABLE RESIDENT.—In this
10 subparagraph, the term ‘applicable resi-
11 dent’ means a resident—

12 “(I) in a specialty which the Sec-
13 retary, in consultation with the Per-
14 manent National Health Workforce
15 Commission established under section
16 101(a) of the Health Access and
17 Health Professions Supply Act of
18 2009, determines is in high-need;

19 “(II) in a health professional
20 shortage area (as defined in section
21 332 of the Public Health Service Act);

22 “(III) in a medically underserved
23 community (as defined in section
24 799B of the Public Health Service
25 Act), or with respect to a medically

underserved population (as defined in section 330(b)(3) of the Public Health Service Act); and

“(IV) in a Federal medical facility.

“(iii) FEDERAL MEDICAL FACILITY.—

In this subparagraph, the term ‘Federal medical facility’ means a facility for the delivery of health services, and includes—

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

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

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

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

1 “(V) a Public Health Service
2 medical facility (used in connection
3 with the delivery of health services
4 under section 320, 321, 322, 324,
5 325, or 326 of such Act); or
6 “(VI) any other Federal medical
7 facility.”.

8 **SEC. 104. DISTRIBUTION OF RESIDENT TRAINEES IN AN**
9 **EMERGENCY.**

10 (a) EXCLUSION FROM 3-YEAR ROLLING AVERAGE.—
11 Notwithstanding any other provision of law, in the case
12 of a host hospital participating in an emergency Medicare
13 GME affiliation agreement on or after the date of enact-
14 ment of this Act and training residents in excess of its
15 cap, consistent with the rolling average provisions applica-
16 ble for closed programs as specified in section
17 413.79(d)(6) of title 42, Code of Federal Regulations, the
18 Secretary of Health and Human Services shall exclude
19 from the 3-year rolling average FTE residents associated
20 with displaced residents during the period in which such
21 agreement is in effect.

22 (b) ASSESSMENT AND REVISION OF GME POLI-
23 CIES.—

24 (1) REVIEW.—The Secretary of Health and
25 Human Services shall review policies with respect to

1 payments for direct graduate medical education
 2 costs under section 1886(h) of the Social Security
 3 Act (42 U.S.C. 1395ww(h)) and payments for the
 4 indirect costs of medical education under section
 5 1886(d)(5)(B) of the Social Security Act (42 U.S.C.
 6 1395ww(d)(5)(B)).

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

9 (A) as appropriate, revise such policies
 10 that constrain the ability of the Secretary to re-
 11 spond to emergency situations and situations
 12 involving institutional and program closure; and

13 (B) in the case where the Secretary deter-
 14 mines legislative action is necessary to make
 15 such revisions, submit to Congress a report con-
 16 taining recommendations for such legislative ac-
 17 tion.

18 **SEC. 105. AUTHORITY TO INCLUDE COSTS OF TRAINING OF**
 19 **PSYCHOLOGISTS IN PAYMENTS TO HOS-**
 20 **PITALS FOR APPROVED EDUCATIONAL AC-**
 21 **TIVITIES UNDER MEDICARE.**

22 Effective for cost reporting periods beginning on or
 23 after the date that is 18 months after the date of enact-
 24 ment of this Act, for purposes of payment to hospitals
 25 under the Medicare program under title XVIII of the So-

1 cial Security Act for costs of approved educational activi-
 2 ties (as defined in section 413.85 of title 42, Code of Fed-
 3 eral Regulations), such approved educational activities
 4 shall include a 1-year doctoral clinical internship operated
 5 by the hospital as part of a clinical psychology training
 6 program that is provided upon completion of university
 7 course work.

8 **Subtitle B—Geriatric Assessments**
 9 **and Chronic Care Management**
 10 **and Coordination Services**
 11 **Under the Medicare Program**

12 **SEC. 111. MEDICARE COVERAGE OF GERIATRIC ASSESS-**
 13 **MENTS.**

14 (a) COVERAGE OF GERIATRIC ASSESSMENTS.—

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

18 (A) in subparagraph (DD), by striking
 19 “and” at the end;

20 (B) in subparagraph (EE), by adding
 21 “and” at the end; and

22 (C) by adding at the end the following new
 23 subparagraph:

24 “(FF) geriatric assessments (as defined in sub-
 25 section (hhh)(1));”.

1 (2) CONFORMING AMENDMENTS.—Clauses (i)
2 and (ii) of section 1861(s)(2)(K) of the Social Secu-
3 rity Act (42 U.S.C. 1395x(s)(2)(K)) are each
4 amended by striking “subsection (ww)(1)” and in-
5 serting “subsections (ww)(1) and (hhh)(1)”.

6 (b) GERIATRIC ASSESSMENTS DEFINED.—Section
7 1861 of the Social Security Act (42 U.S.C. 1395x) is
8 amended by adding at the end the following new sub-
9 sections:

10 “Geriatric Assessment

11 “(hhh)(1) The term ‘geriatric assessment’ means
12 each of the following:

13 “(A) An assessment of the clinical status, func-
14 tional status, social and environmental functioning,
15 and need for caregiving of a geriatric assessment eli-
16 gible individual (as defined in subsection (iii)). The
17 assessment shall include a comprehensive history
18 and physical examination and assessments of the fol-
19 lowing domains using standardized validated clinical
20 tools:

21 “(i) Comprehensive review of medications
22 and the individual’s adherence to the medica-
23 tion regimen.

1 “(ii) Measurement of affect, cognition and
2 executive function, mobility, balance, gait, risk
3 of falling, and sensory function.

4 “(iii) Social functioning, environmental
5 needs, and caregiver resources and needs.

6 “(iv) Any other domain determined appro-
7 priate by the Secretary.

8 “(B) The development of a written care plan
9 based on the results of the assessment under sub-
10 paragraph (A) (and any subsequent assessment
11 under subparagraph (B)). The care plan shall detail
12 identified problems, outline therapies, assign respon-
13 sibility for actions, and indicate whether the indi-
14 vidual is likely to benefit from chronic care manage-
15 ment and coordination services (as defined in sub-
16 section (jjj)(1)). If the individual is determined likely
17 to benefit from chronic care management and co-
18 ordination services, the care plan shall also provide
19 the basis for the chronic care management and co-
20 ordination plan to be developed by the chronic care
21 manager pursuant to subsection (jjj).

22 “(2) A geriatric assessment may only be conducted
23 by—

24 “(A) a physician;

1 “(B) a practitioner described in section
2 1842(b)(18)(C)(i) under the supervision of a physi-
3 cian; or

4 “(C) any other provider that meets such condi-
5 tions as the Secretary may specify.

6 “(3) An individual described in subclause (A), (B),
7 or, if applicable, (C) may provide for the furnishing of
8 services included in the geriatric assessment by other
9 qualified health care professionals.

10 “(4)(A) Subject to subparagraph (B), a geriatric as-
11 sessment of a geriatric assessment eligible individual may
12 not be conducted more frequently than annually.

13 “(B) A geriatric assessment of a geriatric assessment
14 eligible individual may be conducted more frequently than
15 annually if the assessment is medically necessary due to
16 a significant change in the condition of the individual.

17 “Geriatric Assessment Eligible Individual

18 “(iii)(1) Subject to paragraph (3), the term ‘geriatric
19 assessment eligible individual’ means an individual identi-
20 fied by the Secretary as eligible for a geriatric assessment.

21 “(2) In identifying individuals under paragraph (1),
22 the following rules shall apply:

23 “(A) The individual must have at least 1 of the
24 following present:

1 “(i) Multiple chronic conditions that the
2 Secretary identifies as likely to result in high
3 expenditures under this title. In identifying
4 such conditions, the Secretary may consider—

5 “(I) the hierarchal condition category
6 methodology employed for risk adjustment
7 under part C or other comparable meth-
8 odologies the Secretary deems appropriate;

9 “(II) data from the Chronic Condition
10 Data Warehouse under section 723 of the
11 Medicare Prescription Drug, Improvement,
12 and Modernization Act of 2003; and

13 “(III) indicators of geriatric syn-
14 dromes, such as experiencing 2 or more
15 falls in the past year, urinary incontinence,
16 clinically significant depression, or other
17 such indicators that the Secretary indicates
18 as likely to result in high expenditures
19 under this title when they exist in com-
20 bination with one or more chronic condi-
21 tions).

22 “(ii) Dementia, as defined in the most re-
23 cent Diagnostic and Statistical Manual of Men-
24 tal Disorders, and at least 1 other chronic con-
25 dition.

1 “(iii) Any other factor identified by the
2 Secretary.

3 “(B) The Secretary shall consult with physi-
4 cians, physician groups and organizations, other
5 health care professional groups and organizations,
6 organizations representing individuals with chronic
7 conditions and older adults, and other stakeholders
8 in identifying conditions under clauses (i) and (ii) of
9 subparagraph (A) and any factors under subpara-
10 graph (A)(iii).

11 “(3) The term ‘geriatric assessment eligible indi-
12 vidual’ shall not include the following individuals:

13 “(A) An individual who is receiving hospice care
14 under this title.

15 “(B) An individual who is residing in a skilled
16 nursing facility, a nursing facility (as defined in sec-
17 tion 1919), or any other facility identified by the
18 Secretary.

19 “(C) An individual medically determined to
20 have end-stage renal disease.

21 “(D) An individual enrolled in a Medicare Ad-
22 vantage plan or a plan under section 1876.

23 “(E) An individual enrolled in a PACE pro-
24 gram under section 1894.

1 “(F) Any other categories of individuals deter-
2 mined appropriate by the Secretary.

3 “(4) For purposes of this subsection, the term ‘chron-
4 ic condition’ means a condition, such as dementia, that
5 lasts or is expected to last 1 year or longer, limits what
6 an individual can do, and requires ongoing care.”.

7 (c) PAYMENT AND ELIMINATION OF COST-SHAR-
8 ING.—

9 (1) PAYMENT AND ELIMINATION OF COINSUR-
10 ANCE.—Section 1833(a)(1) of the Social Security
11 Act (42 U.S.C. 1395l(a)(1)) is amended—

12 (A) in subparagraph (N), by inserting
13 “other than geriatric assessments (as defined in
14 section 1861(hhh)(1))” after “(as defined in
15 section 1848(j)(3))”;

16 (B) by striking “and” before “(W)”;

17 (C) by inserting before the semicolon at
18 the end the following: “, and (X) with respect
19 to geriatric assessments (as defined in section
20 1861(hhh)(1)), the amount paid shall be 100
21 percent of the lesser of the actual charge for
22 the services or the amount determined under
23 section 1848(o)”.

24 (2) PAYMENT.—

1 (A) IN GENERAL.—Section 1848 of the So-
 2 cial Security Act (42 U.S.C. 1395w-4) is
 3 amended by adding at the end the following
 4 new subsection:

5 “(p) PAYMENT FOR GERIATRIC ASSESSMENTS.—

6 “(1) ESTABLISHMENT.—

7 “(A) IN GENERAL.—The Secretary shall
 8 establish—

9 “(i) a payment code (or codes) under
 10 this section for a geriatric assessment (as
 11 defined in section 1861(hhh)(1)) furnished
 12 to a geriatric assessment eligible individual
 13 (as defined in section 1861(iii)) by a physi-
 14 cian, practitioner, or other provider de-
 15 scribed in section 1861(hhh)(2); and

16 “(ii) a payment amount for each such
 17 code.

18 “(B) REQUIREMENTS.—In establishing
 19 payment amounts under subparagraph (A)(ii),
 20 the Secretary shall—

21 “(i) take into account—

22 “(I) the amount of work required
 23 to perform a geriatric assessment, in-
 24 cluding the time and effort put forth
 25 by each qualified health care profes-

sional involved in performing the geriatric assessment; and

“(II) all of the costs associated with the geriatric assessment, including labor, supplies, equipment, and the costs of health information technologies and systems incurred by the physician, practitioner, or other provider (as described in section 1861(hhh)(2)) in providing the assessment; and

“(ii) ensure that such payments do not result in a reduction in payments for office visits or other evaluation and management services that would otherwise be allowable.

“(2) SEPARATE PAYMENTS FROM PAYMENTS FOR CHRONIC CARE MANAGEMENT AND COORDINATION SERVICES.—Payments for geriatric assessments shall be made separately from payments for chronic care management and coordination services (as defined in section 1861(jjj)(1)) and other services for which payment is made under this title.”.

(B) CONFORMING AMENDMENT.—Section 1848(j)(3) of the Social Security Act (42

1 U.S.C. 1395w-4(j)(3)), as amended by section
 2 111(c)(2)), is amended by inserting “(2)(FF),”
 3 after “(2)(EE),”.

4 (3) ELIMINATION OF COINSURANCE IN OUT-
 5 PATIENT HOSPITAL SETTINGS.—

6 (A) EXCLUSION FROM OPD FEE SCHED-
 7 ULE.—Section 1833(t)(1)(B)(iv) of the Social
 8 Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is
 9 amended by striking “and diagnostic mammog-
 10 raphy” and inserting “, diagnostic mammog-
 11 raphy, or geriatric assessments (as defined in
 12 section 1861(hhh)(1))”.

13 (B) CONFORMING AMENDMENTS.—Section
 14 1833(a)(2) of the Social Security Act (42
 15 U.S.C. 1395l(a)(2)) is amended—

16 (i) in subparagraph (F), by striking
 17 “and” at the end;

18 (ii) in subparagraph (G)(ii), by strik-
 19 ing the comma at the end and inserting “;
 20 and”; and

21 (iii) by inserting after subparagraph
 22 (G)(ii) the following new subparagraph:

23 “(H) with respect to geriatric assessments
 24 (as defined in section 1861(hhh)(1)) furnished

1 by an outpatient department of a hospital, the
 2 amount determined under paragraph (1)(X),”.

3 (4) ELIMINATION OF DEDUCTIBLE.—The first
 4 sentence of section 1833(b) of the Social Security
 5 Act (42 U.S.C. 1395l(b)) is amended—

6 (A) by striking “and” before “(9)”; and

7 (B) by inserting before the period the fol-
 8 lowing: “, and (10) such deductible shall not
 9 apply with respect to geriatric assessments (as
 10 defined in section 1861(hhh)(1))”.

11 (d) FREQUENCY LIMITATION.—Section 1862(a) of
 12 the Social Security Act (42 U.S.C. 1395y(a)(1)) is amend-
 13 ed—

14 (1) in paragraph (1)—

15 (A) in subparagraph (N), by striking
 16 “and” at the end;

17 (B) in subparagraph (O) by striking the
 18 semicolon at the end and inserting “, and”; and

19 (C) by adding at the end the following new
 20 subparagraph:

21 “(P) in the case of geriatric assessments (as de-
 22 fined in section 1861(hhh)(1)), which are performed
 23 more frequently than is covered under such sec-
 24 tion;”; and

1 (2) in paragraph (7), by striking “or (K)” and
2 inserting “(K), or (P)”.

3 (e) EXCEPTION TO LIMITS ON PHYSICIAN REFER-
4 RALS.—Section 1877(b) of the Social Security Act (42
5 U.S.C. 1395nn(b)) is amended by adding at the end the
6 following new paragraph:

7 “(6) GERIATRIC ASSESSMENTS.—In the case of
8 a designated health service, if the designated health
9 service is a geriatric assessment (as defined in sec-
10 tion 1861(hhh)(1)) and furnished by a physician.”.

11 (f) RULEMAKING.—The Secretary of Health and
12 Human Services shall define such terms, establish such
13 procedures, and promulgate such regulations as the Sec-
14 retary determines necessary to implement the amend-
15 ments made by, and the provisions of, this section, includ-
16 ing the establishment of additional domains under sub-
17 section (hhh)(1)(A)(iv) of section 1861 of the Social Secu-
18 rity Act, as added by subsection (b). In promulgating such
19 regulations, the Secretary shall consult with physicians,
20 physician groups and organizations, other health care pro-
21 fessional groups and organizations representing individ-
22 uals with chronic conditions and older adults.

23 (g) EFFECTIVE DATE.—The amendments made by
24 this section shall apply to assessments furnished on or
25 after January 1, 2010.

1 **SEC. 112. MEDICARE COVERAGE OF CHRONIC CARE MAN-**
 2 **AGEMENT AND COORDINATION SERVICES.**

3 (a) PART B COVERAGE OF CHRONIC CARE MANAGE-
 4 MENT AND COORDINATION SERVICES.—

5 (1) IN GENERAL.—Section 1861(s)(2) of the
 6 Social Security Act (42 U.S.C. 1395x(s)(2)), as
 7 amended by section 111(a)(1), is amended—

8 (A) in subparagraph (EE), by striking
 9 “and” at the end;

10 (B) in subparagraph (FF), by adding
 11 “and” at the end; and

12 (C) by adding at the end the following new
 13 subparagraph:

14 “(GG) chronic care management and coordina-
 15 tion services (as defined in subsection (jjj));”.

16 (2) CONFORMING AMENDMENTS.—(A) Clauses
 17 (i) and (ii) of section 1861(s)(2)(K) of the Social Se-
 18 curity Act (42 U.S.C. 1395x(s)(2)(K)), as amended
 19 by section 111(a)(2), are each amended by striking
 20 “subsections (ww)(1) and (hhh)(1)” and inserting
 21 “subsections (ww)(1), (hhh)(1), and (jjj)(1)”.

22 (B) Section 1862(a)(7) of the Social Security
 23 Act (42 U.S.C. 1395y(a)(7)), as amended by section
 24 111(d), is amended by striking “section
 25 1861(s)(10)” and inserting “paragraphs (2)(GG)
 26 and (10) of section 1861(s)”.

1 (b) SERVICES DESCRIBED.—Section 1861 of the So-
2 cial Security Act (42 U.S.C. 1395x), as amended by sec-
3 tion 111(b), is amended by adding at the end the following
4 new subsection:

5 “Chronic Care Management and Coordination Services;
6 Chronic Care Manager; Chronic Care Eligible Individual

7 “(jjj)(1) The term ‘chronic care management and co-
8 ordination services’ means services that are furnished to
9 a chronic care eligible individual (as defined in paragraph
10 (3)) by, or under the supervision of, a single chronic care
11 manager (as defined in paragraph (2)) chosen by the
12 chronic care eligible individual, a caregiver designated by
13 the individual in writing, or a representative authorized
14 to make decisions on the individual’s behalf, under a plan
15 of care prescribed by such chronic care manager for the
16 purpose of chronic care coordination, including dementia
17 as appropriate, which may include any of the following
18 services:

19 “(A) The development of an initial plan of care
20 (based on the results of a geriatric assessment, as
21 defined in subsection (hhh)), and subsequent appro-
22 priate revisions to that plan of care.

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

1 disciplinary care conferences and management with
2 other providers.

3 “(C) The monitoring and management of medi-
4 cations.

5 “(D) Patient education and counseling services.

6 “(E) Family caregiver education and counseling
7 services, including preventive care consistent with
8 the patient’s condition.

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

12 “(G) Providing access for individuals, and care-
13 givers or authorized representatives as appropriate,
14 by telephone and e-mail to physicians or other ap-
15 propriate health care professionals, including 24-
16 hour availability of such professionals for after hours
17 consultation.

18 “(H) Coordination with the principal nonprofes-
19 sional caregiver in the home.

20 “(I) Managing and facilitating transitions that
21 occur among health care professionals and across
22 settings of care, including the following:

23 “(i) Pursuing the treatment option elected
24 by the individual.

1 “(ii) Including any advance directive exe-
2 cuted by the individual in the medical file of the
3 individual.

4 “(J) Information about pain management and
5 palliative care.

6 “(K) Information about, and referral to, hos-
7 pice care, including patient and family caregiver
8 education and counseling about hospice care, and fa-
9 cilitating transition to hospice care when elected.

10 “(L) Information about, referral to, and coordi-
11 nation with, community resources.

12 “(M) Such additional services for which pay-
13 ment would not otherwise be made under this title
14 that the Secretary may specify that encourage the
15 receipt of, or improve the effectiveness of, the serv-
16 ices described in the preceding subparagraphs.

17 “(2)(A) For purposes of this subsection, the term
18 ‘chronic care manager’ means an individual or entity
19 that—

20 “(i) is—

21 “(I) a physician;

22 “(II) a practitioner described in clause (i)
23 or (iv) of section 1842(b)(18)(C); or

24 “(III) any other provider that meets such
25 conditions as the Secretary may specify;

1 “(ii) has entered into a chronic care manage-
2 ment and coordination agreement with the Sec-
3 retary; and

4 “(iii) is working in collaboration with, or under
5 the supervision of, as determined by the Secretary—

6 “(I) the physician, practitioner, or other
7 provider who completed the geriatric assessment
8 of the individual; or

9 “(II) a physician, practitioner, or other
10 provider to whom the individual’s care was
11 transferred by the physician, practitioner, or
12 other provider who performed the geriatric as-
13 sessment.

14 “(B)(i) For purposes of subparagraph (A)(ii), each
15 chronic care management and coordination agreement
16 shall meet the requirements described in subparagraph
17 (C) and shall—

18 “(I) subject to clause (ii), be entered into for a
19 period of 3 years and may be renewed if the Sec-
20 retary is satisfied that the chronic care manager
21 continues to meet such terms and conditions as the
22 Secretary may require; and

23 “(II) contain such other terms and conditions
24 as the Secretary may require.

1 “(ii) Each chronic care management and coordination
2 agreement shall provide for the termination of such agree-
3 ment prior to such 3-year period in the case where the
4 chronic care manager—

5 “(I) is no longer able to provide chronic care
6 services; or

7 “(II) does not meet such terms and conditions
8 as the Secretary may require.

9 “(C)(i) Subject to clause (ii), the requirements of this
10 subparagraph are met if the agreement requires the chron-
11 ic care manager to perform, or provide for the perform-
12 ance of, the following services:

13 “(I) Advocating for, and providing ongoing sup-
14 port, oversight, and guidance with respect to the im-
15 plementation of a plan of care that provides an inte-
16 grated, coherent, and cross-disciplined plan for ongo-
17 ing medical care that is developed in partnership
18 with the chronic care eligible individual and all other
19 physicians and other care providers and agencies (in-
20 cluding home health agencies) providing care to the
21 chronic care eligible individual.

22 “(II) Using evidence-based medicine and clin-
23 ical decision support tools to guide decisionmaking
24 at the point of care and on the basis of specific pa-
25 tient factors.

1 “(III) Using health information technology, in-
2 cluding, where appropriate, remote monitoring and
3 patient registries, to monitor and track the health
4 status of patients and to provide patients with en-
5 hanced and convenient access to health care services.

6 “(IV) Encouraging patients to engage in the
7 management of their own health through education
8 and support systems.

9 “(V) Incorporating family caregivers into the
10 chronic care planning process.

11 “(ii) The Secretary may modify the services required
12 under the agreement under clause (i), including by requir-
13 ing different services or services in addition to those de-
14 scribed in subclauses (I) through (V) of such clause.

15 “(D) The Secretary shall adopt procedures which ex-
16 empt providers in rural areas from providing 1 or more
17 of the services otherwise required to be provided under
18 subparagraph (C) or modify such requirements for such
19 providers. In establishing such procedures, the Secretary
20 shall ensure that such exemptions and modifications do
21 not impact the quality of chronic care management and
22 coordination services furnished by such providers.

23 “(3) For purposes of this subsection, the term ‘chron-
24 ic care eligible individual’ means a geriatric assessment
25 eligible individual (as defined in subsection (iii)) who has

1 undergone a geriatric assessment (as defined in subsection
 2 (hhh)(1)) which determined that the individual would ben-
 3 efit from chronic care management and coordination.

4 “(4) Chronic care management and coordination
 5 services may be furnished in the chronic care eligible indi-
 6 vidual’s home or residence.”.

7 (c) PAYMENT AND ELIMINATION OF COST-SHAR-
 8 ING.—

9 (1) PAYMENT AND ELIMINATION OF COINSUR-
 10 ANCE.—Section 1833(a)(1) of the Social Security
 11 Act (42 U.S.C. 1395l(a)(1)), as amended by section
 12 111(c)(1), is amended—

13 (A) in subparagraph (N), by inserting “or
 14 chronic care management and coordination
 15 services (as defined in section 1861(jjj)(1))”
 16 after “other than geriatric assessments (as de-
 17 fined in section 1861(hhh)(1))”;

18 (B) by striking “and” before “(X)”; and

19 (C) by inserting before the semicolon at
 20 the end the following: “, and (Y) with respect
 21 to chronic care management and coordination
 22 services (as defined in section 1861(jjj)(1)), the
 23 amount paid shall be 100 percent of the lesser
 24 of the actual charge for the services or the
 25 amount determined under section 1848(p)”.

1 (2) PAYMENT.—

2 (A) IN GENERAL.—Section 1848 of the So-
3 cial Security Act (42 U.S.C. 1395w-4), as
4 amended by section 111(c)(2), is amended by
5 adding at the end the following new subsection:

6 “(q) PAYMENT FOR CHRONIC CARE MANAGEMENT
7 AND COORDINATION SERVICES.—

8 “(1) ESTABLISHMENT.—

9 “(A) IN GENERAL.—The Secretary shall
10 establish—

11 “(i) a payment code (or codes) under
12 this section for chronic care management
13 and coordination services (as defined in
14 paragraph (1) of section 1861(jjj)) fur-
15 nished to a chronic care eligible individual
16 (as defined in paragraph (3) of such sec-
17 tion) by a chronic care manager (as de-
18 fined in paragraph (2) of such section);
19 and

20 “(ii) a payment amount for each such
21 code.

22 “(B) REQUIREMENTS.—In establishing
23 payment amounts under subparagraph (A)(ii),
24 the Secretary shall—

25 “(i) take into account—

1 “(I) the amount of work required
2 of the chronic care manager in pro-
3 viding chronic care management and
4 coordination services to eligible indi-
5 viduals; and

6 “(II) all of the costs associated
7 with providing chronic care manage-
8 ment and coordination services, in-
9 cluding labor, supplies, equipment,
10 and the costs of health information
11 technologies and systems incurred by
12 the chronic care manager in providing
13 such services;

14 “(ii) ensure that such payments are
15 for such services furnished during a 30-day
16 period; and

17 “(iii) ensure that such payments do
18 not result in a reduction in payments for
19 office visits or other evaluation and man-
20 agement services that would otherwise be
21 allowable.

22 “(2) SEPARATE PAYMENTS FROM PAYMENTS
23 FOR GERIATRIC ASSESSMENTS.—Payments for
24 chronic care management and coordination services
25 shall be made separately from payments for geriatric

1 assessments (as defined in section 1861(hhh)(1))
 2 and other services for which payment is made under
 3 this title.”.

4 (B) CONFORMING AMENDMENT.—Section
 5 1848(j)(3) of the Social Security Act (42
 6 U.S.C. 1395w-4(j)(3)), as amended by section
 7 111(c)(2)), is amended by inserting “(2)(GG),”
 8 after “(2)(FF),”.

9 (3) ELIMINATION OF COINSURANCE IN OUT-
 10 PATIENT HOSPITAL SETTINGS.—

11 (A) EXCLUSION FROM OPD FEE SCHED-
 12 ULE.—Section 1833(t)(1)(B)(iv) of the Social
 13 Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)), as
 14 amended by section 111(c)(3)(A), is amended
 15 by striking “or geriatric assessments (as de-
 16 fined in section 1861(hhh)(1))” and inserting
 17 “geriatric assessments (as defined in section
 18 1861(hhh)(1)), or chronic care management
 19 and coordination services (as defined in section
 20 1861(jjj)(1))”.

21 (B) CONFORMING AMENDMENTS.—Section
 22 1833(a)(2) of the Social Security Act (42
 23 U.S.C. 1395l(a)(2)), as amended by section
 24 111(c)(3)(B), is amended—

1 (i) in subparagraph (G)(ii), by strik-
 2 ing “and” at the end;

3 (ii) in subparagraph (H), by striking
 4 the comma at the end and inserting “;
 5 and”; and

6 (iii) by inserting after subparagraph
 7 (H) the following new subparagraph:

8 “(I) with respect to chronic care manage-
 9 ment and coordination services (as defined in
 10 section 1861(jjj)(1)) furnished by an outpatient
 11 department of a hospital, the amount deter-
 12 mined under paragraph (1)(Y),”.

13 (4) ELIMINATION OF DEDUCTIBLE.—Paragraph
 14 (10) of section 1833(b) of the Social Security Act
 15 (42 U.S.C. 1395l(b)), as added by section 111(c)(4),
 16 is amended by inserting “or chronic care manage-
 17 ment and coordination services (as defined in section
 18 1861(jjj)(1))” after “geriatric assessments (as de-
 19 fined in section 1861(hhh)(1))”.

20 (d) EXCEPTION TO LIMITS ON PHYSICIAN REFER-
 21 RALS.—Section 1877(b)(6) of the Social Security Act (42
 22 U.S.C. 1395nn(b)(6)), as amended by section 111(e), is
 23 amended to read as follows:

24 “(6) GERIATRIC ASSESSMENTS AND CHRONIC
 25 CARE MANAGEMENT AND COORDINATION SERV-

1 ICES.—In the case of a designated health service, if
2 the designated health service is—

3 “(A) a geriatric assessment or a chronic
4 care management and coordination service (as
5 defined in subsections (hhh)(1) or (jjj)(1) of
6 section 1861, respectively); and

7 “(B) furnished by a physician.”.

8 (e) RULEMAKING.—The Secretary of Health and
9 Human Services shall define such terms, establish such
10 procedures, and promulgate such regulations as the Sec-
11 retary determines necessary to implement the amend-
12 ments made by, and the provisions of, this section. In pro-
13 mulgating such regulations, the Secretary shall consult
14 with physicians, physician groups and organizations, other
15 health care professional groups and organizations, and or-
16 ganizations representing individuals with chronic condi-
17 tions and older adults.

18 (f) EFFECTIVE DATE.—The amendments made by
19 this section shall apply to chronic care management and
20 coordination services furnished on or after January 1,
21 2010.

1 **SEC. 113. OUTREACH ACTIVITIES REGARDING GERIATRIC**
 2 **ASSESSMENTS AND CHRONIC CARE MANAGE-**
 3 **MENT AND COORDINATION SERVICES UNDER**
 4 **THE MEDICARE PROGRAM.**

5 The Secretary of Health and Human Services shall
 6 conduct outreach activities to individuals likely to be eligi-
 7 ble to receive coverage of geriatric assessments (as defined
 8 in subsection (hhh)(1) of section 1861 of the Social Secu-
 9 rity Act, as added by section 111) under the Medicare pro-
 10 gram and individuals likely to be eligible to receive cov-
 11 erage of chronic care management and coordination serv-
 12 ices (as defined in subsection (jjj)(1) of such section 1861,
 13 as added by section 112) under the Medicare program,
 14 to inform such individuals about the availability of such
 15 benefits under the Medicare program.

16 **SEC. 114. UTILIZATION OF TELEHEALTH SERVICES TO FUR-**
 17 **NISH GERIATRIC ASSESSMENTS AND CHRON-**
 18 **IC CARE MANAGEMENT AND COORDINATION**
 19 **SERVICES UNDER THE MEDICARE PROGRAM.**

20 (a) IN GENERAL.—Section 1834(m)(4)(F) of the So-
 21 cial Security Act (42 U.S.C. 1395m(m)(4)(F)) is amended
 22 by adding at the end the following new clause:

23 “(iii) GERIATRIC ASSESSMENTS AND
 24 CHRONIC CARE MANAGEMENT AND CO-
 25 ORDINATION SERVICES.—The term ‘tele-
 26 health service’ shall also include geriatric

1 assessments (as defined in section
 2 1861(hhh)(1)) and chronic care manage-
 3 ment and coordination services (as defined
 4 in section 1861(ijj)).”.

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

8 **SEC. 115. STUDY AND REPORT ON GERIATRIC ASSESS-**
 9 **MENTS AND CHRONIC CARE MANAGEMENT**
 10 **AND COORDINATION SERVICES UNDER THE**
 11 **MEDICARE PROGRAM.**

12 (a) STUDY.—The Secretary of Health and Human
 13 Services shall enter into a contract with an entity to con-
 14 duct a study on—

15 (1) the effectiveness of the coverage of geriatric
 16 assessments and chronic care management and co-
 17 ordination services, including an evaluation of the
 18 use of interdisciplinary teams in providing such serv-
 19 ices, under the Medicare program (under the amend-
 20 ments made by sections 3 and 4) on improving the
 21 quality of care provided to Medicare beneficiaries
 22 with chronic conditions, including dementia; and

23 (2) the impact of such geriatric assessments
 24 and care coordination services on reducing expendi-
 25 tures under title XVIII of the Social Security Act,

1 including reduced expenditures that may result
2 from—

3 (A) reducing preventable hospital admis-
4 sions;

5 (B) more appropriate use of pharma-
6 ceuticals; and

7 (C) reducing duplicate or unnecessary
8 tests.

9 (b) REPORT.—Not later than 3 years after the date
10 of enactment of this Act, the entity conducting the study
11 under subsection (a) shall submit to Congress and the Sec-
12 retary of Health and Human Services a report on the
13 study, together with recommendations for such legislation
14 or administrative action as such entity determines appro-
15 priate.

16 (c) AUTHORIZATION OF APPROPRIATIONS.—There
17 are authorized to be appropriated such sums as may be
18 necessary to carry out this section.

19 **SEC. 116. RULE OF CONSTRUCTION.**

20 Nothing in the provisions of, or in the amendments
21 made by, this subtitle shall be construed as requiring an
22 individual to receive a geriatric assessment (as defined in
23 section 1861(hhh)(1) of the Social Security Act, as added
24 by section 111(b)) or chronic care management and co-

1 ordination services (as defined in section 1861(jjj)(1) of
 2 such Act, as added by section 112(b)).

3 **TITLE II—AMENDMENTS TO THE** 4 **PUBLIC HEALTH SERVICE ACT**

5 **SEC. 201. EXPANSION OF NATIONAL HEALTH SERVICE** 6 **CORPS PROGRAMS.**

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

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

11 “(1) for fiscal year 2009, \$165,000,000;

12 “(2) for fiscal year 2010, \$198,000,000;

13 “(3) for fiscal year 2011, \$231,000,000;

14 “(4) for fiscal year 2012, \$264,000,000;

15 “(5) for fiscal year 2013, \$297,000,000; and

16 “(6) for fiscal year 2014, \$330,000,000.”; and

17 (2) by adding at the end the following:

18 “(d) EXPANSION OF PROGRAMS.—The Secretary
 19 shall use amounts appropriated for each of fiscal years
 20 2010 through 2014 under subsection (a), that are in ex-
 21 cess of the amount appropriated under such subsection for
 22 fiscal year 2009, to address shortages of health profes-
 23 sionals in rural, frontier, and urban underserved areas
 24 through an expansion of the number of scholarships and
 25 loan repayments under this subpart to address health

1 workforce shortages in health professional shortage areas
2 (as defined in section 332), in medically underserved com-
3 munities (as defined in section 799B), or with respect to
4 medically underserved populations (as defined in section
5 330(b)(3)).”.

6 (b) EXPANSION OF OTHER PROGRAMS.—The Direc-
7 tor of the Indian Health Service, the Secretary of Defense,
8 and the Secretary of Veterans Affairs, shall expand exist-
9 ing loan repayment programs to emphasize the provision
10 of health professions services to facilities that have health
11 professional shortages.

12 (c) NO TAX IMPLICATIONS.—

13 (1) IN GENERAL.—For purposes of the Internal
14 Revenue Code of 1986, any amount received under
15 a health-related Federal loan repayment program by
16 a health professional providing health-related serv-
17 ices in a Federal medical facility shall not be in-
18 cluded in the gross income of such professional.

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

22 (A) a federally qualified health center (as
23 defined in section 330A of the Public Health
24 Service Act (42 U.S.C. 254c)), a public health

1 center, an outpatient medical facility, or a com-
 2 munity mental health center;

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

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

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

11 (E) a Public Health Service medical facil-
 12 ity (used in connection with the delivery of
 13 health services under section 320, 321, 322,
 14 324, 325, or 326 of such Act (42 U.S.C. 247e,
 15 248, 249, 251, 252, or 253));

16 (F) a nurse-managed health center; or

17 (G) any other Federal medical facility.

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

22 “(e) Notwithstanding any other provision of this sub-
 23 part, the Secretary shall develop procedures to permit pe-
 24 riods of obligated services to be provided on a part-time
 25 basis (not less than 1,040 hours of such service per year).

1 Such procedures shall prohibit an individual from holding
2 other part-time employment while providing such part-
3 time obligated services. The Secretary may provide for a
4 reduction in the loan repayments provided to individuals
5 who provide part-time obligated services under the author-
6 ity provided under this subsection.”.

7 (e) LOAN SUPPORT FOR PARTICIPATING PRECEP-
8 TORS, MENTORS, AND ATTENDINGS TO SUPERVISE STU-
9 DENTS AND TRAINEES ON-SITE.—Section 338C of the
10 Public Health Service Act (42 U.S.C. 254m), as amended
11 by subsection (d), is further amended by adding at the
12 end the following:

13 “(f) The Secretary shall develop procedures to permit
14 up to 20 percent of the service obligation of an individual
15 under this section to be provided by the individual through
16 precepting or mentoring activities, or by preparing cur-
17 riculum, for on-site students and trainees. The procedures
18 developed under subsection (e) shall provide for the pro-
19 portional application of this subsection with respect to in-
20 dividual providing obligated service on a part-time basis.”.

1 SEC. 202. NATIONAL HEALTH SERVICE CORPS SCHOLAR-
2 SHIP PROGRAM FOR MEDICAL, DENTAL, PHY-
3 SICIAN ASSISTANT, PHARMACY, BEHAVIORAL
4 AND MENTAL HEALTH, PUBLIC HEALTH, AND
5 NURSING STUDENTS IN THE UNITED STATES
6 PUBLIC HEALTH SCIENCES TRACK IN AFFILI-
7 ATED SCHOOLS.

8 (a) PROGRAM AUTHORIZED.—

9 (1) IN GENERAL.—Subpart III of part D of
10 title III of the Public Health Service Act (42 U.S.C.
11 254l et seq.) is amended—

12 (A) in the heading by inserting “, **Schol-**
13 **arship Program for Medical, Dental,**
14 **Physician Assistant, Pharmacy, Be-**
15 **havioral and Mental Health, Public**
16 **Health, and Nursing Students in the**
17 **United States Public Health Sciences**
18 **Track in Affiliated Schools,”** after
19 **“Scholarship Program”**; and

20 (B) by inserting after section 338A the fol-
21 lowing:

1 **“SEC. 338A–1. NATIONAL HEALTH SERVICE CORPS SCHOL-**
2 **ARSHIP PROGRAM FOR MEDICAL, DENTAL,**
3 **PHYSICIAN ASSISTANT, PHARMACY, BEHAV-**
4 **IORAL AND MENTAL HEALTH, PUBLIC**
5 **HEALTH, AND NURSING STUDENTS IN THE**
6 **UNITED STATES PUBLIC HEALTH SCIENCES**
7 **TRACK IN AFFILIATED SCHOOLS.**

8 “(a) ESTABLISHMENT.—

9 “(1) IN GENERAL.—The Secretary shall estab-
10 lish a program to be known as the National Health
11 Service Corps Scholarship Program for Medical,
12 Dental, Physician Assistant, Pharmacy, Behavioral
13 and Mental Health, Public Health, and Nursing Stu-
14 dents in the United States Public Health Sciences
15 Track in Affiliated Schools (in this section referred
16 to as the ‘U.S. Public Health Sciences Track Schol-
17 arship Program’) to ensure, with respect to the pro-
18 vision of high-needs health care services, including
19 primary care, general dentistry, nursing, obstetrics,
20 and geriatricians pursuant to section 331(a)(2), an
21 adequate supply of physicians, physician assistants,
22 pharmacists, behavioral and mental health profes-
23 sionals, public health professionals, dentists, and
24 nurses. The purpose of this program is to train an
25 additional 150 medical students, 100 dental stu-
26 dents, 100 physician assistant students, 100 behav-

1 ioral and mental health students, 100 public health
2 students, and 250 nursing students during each
3 year. Of the 150 scholarships awarded to the med-
4 ical students as described under the preceding sen-
5 tence, 10 shall be for training at the Uniformed
6 Services University of the Health Sciences as mem-
7 bers of the Commissioned Corps of the Public
8 Health Service.

9 “(2) RELATIONSHIP TO NATIONAL HEALTH
10 SERVICE CORPS SCHOLARSHIP PROGRAM.—Scholar-
11 ships provided under this section are intended to
12 complement, and not take the place of, scholarships
13 provided to students enrolled in courses of study
14 leading to a degree in medicine, osteopathic medi-
15 cine, dentistry, or nursing or completion of an ac-
16 credited physician assistant, pharmacy, public
17 health, or behavioral and mental health educational
18 program under the National Health Service Corps
19 Scholarship Program authorized by section 338A.

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

23 “(1) be accepted for enrollment as a full-time
24 student—

1 “(A) in an accredited (as determined by
2 the Secretary) educational institution in a
3 State; and

4 “(B) in a course of study, or program, of-
5 fered by such institution leading to a degree in
6 medicine, osteopathic medicine, dentistry, physi-
7 cian assistant, pharmacy, behavioral and mental
8 health, public health, or nursing;

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

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

16 “(4) sign and submit to the Secretary, at the
17 time of submittal of such application, a written con-
18 tract to accept payment of a scholarship and to
19 serve (in accordance with this subpart) for the appli-
20 cable period of obligated service in an area in which
21 the need for public health-related services may be
22 demonstrated.”.

23 (2) NO TAX IMPLICATIONS.—For purposes of
24 the Internal Revenue Code of 1986, any amount re-
25 ceived under the National Health Service Corps

1 Scholarship Program for Medical, Dental and Nurs-
2 ing Students in the United States Public Health
3 Sciences Track in Affiliated Schools under section
4 338A–1 of the Public Health Service Act, as added
5 by paragraph (1), by a medical student, dental stu-
6 dent, or nursing student shall not be included in the
7 gross income of such student.

8 (b) GRANTS TO INCREASE THE NUMBER OF AVAIL-
9 ABLE SLOTS FOR NEWLY ADMITTED MEDICAL, DENTAL,
10 PHYSICIAN ASSISTANT, PHARMACY, BEHAVIORAL AND
11 MENTAL HEALTH, PUBLIC HEALTH, AND NURSING STU-
12 DENTS AND TO INCREASE PARTICIPATION IN THE U.S.
13 PUBLIC HEALTH SCIENCES TRACK SCHOLARSHIP PRO-
14 GRAM.—Part C of title VII of the Public Health Service
15 Act (42 U.S.C. 293k et seq.) is amended by adding at
16 the end the following:

1 **“SEC. 749. GRANTS TO INCREASE THE NUMBER OF AVAIL-**
2 **ABLE SLOTS FOR NEWLY ADMITTED MED-**
3 **ICAL, DENTAL, PHYSICIAN ASSISTANT, PHAR-**
4 **MACY, BEHAVIORAL AND MENTAL HEALTH,**
5 **PUBLIC HEALTH, AND NURSING STUDENTS**
6 **AND TO INCREASE PARTICIPATION IN THE**
7 **U.S. PUBLIC HEALTH SCIENCES TRACK**
8 **SCHOLARSHIP PROGRAM.**

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

13 “(1) To increase the capacity of the recipient
14 medical, dental, public health, or nursing school or
15 physician assistant, pharmacy, or behavioral and
16 mental health program, to accept additional medical,
17 dental, public health, nursing, physician assistant,
18 pharmacy, or behavioral and mental health students
19 each year.

20 “(2) To develop curriculum.

21 “(3) To acquire equipment.

22 “(4) To recruit, train, and retain faculty.

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

1 program during the period in which such students
2 are completing a residency or internship program af-
3 filiated with the recipient institution.

4 “(b) APPLICATION.—A medical, dental, public health,
5 or nursing school or physician assistant, pharmacy, or be-
6 havioral and mental health program seeking a grant under
7 this section shall submit an application to the Secretary
8 at such time, in such manner, and containing such infor-
9 mation as the Secretary may require.

10 “(c) DEFINITION OF MEDICAL SCHOOL.—In this sec-
11 tion, the term ‘medical school’ means a school of medicine
12 or a school of osteopathic medicine.”.

13 **SEC. 203. FEDERAL MEDICAL FACILITY GRANT PROGRAM**
14 **AND PROGRAM ASSESSMENTS.**

15 (a) FEDERAL MEDICAL FACILITY GRANT PRO-
16 GRAM.—Title VII of the Public Health Service Act (42
17 U.S.C. 292 et seq.) is amended—

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

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

1 **“PART F—START-UP EXPENSES LOAN AND GRANT**
 2 **PROGRAMS FOR FEDERAL MEDICAL FACILI-**
 3 **TIES AND HOSPITALS STARTING HIGH**
 4 **NEEDS RESIDENCY PROGRAMS IN SHORT-**
 5 **AGE AREAS**

6 **“SEC. 781. FEDERAL MEDICAL FACILITY GRANT PROGRAM.**

7 “(a) IN GENERAL.—The Secretary shall award
 8 grants to eligible facilities to increase interdisciplinary,
 9 community-based health professions training in high-needs
 10 specialties for physicians, nurses, dentists, physician as-
 11 sistants, pharmacy, behavioral and mental health profes-
 12 sionals, public health professionals, and other health pro-
 13 fessionals as determined appropriate by the Secretary, in
 14 consultation with the Permanent National Health Work-
 15 force Commission established under section 101(a) of the
 16 Health Access and Health Professions Supply Act of
 17 2009.

18 “(b) ELIGIBLE FACILITIES; APPLICATION.—

19 “(1) DEFINITION OF ELIGIBLE FACILITY.—In
 20 this section, the term ‘eligible facility’—

21 “(A) means a facility which—

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

24 “(ii) is located in a medically under-
 25 served community (as defined in section
 26 799B), or with respect to a medically un-

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

“(iii) is a Federal medical facility;

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

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

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

1 zations (as defined in section 4 of the Indian
2 Health Care Improvement Act), and other Fed-
3 eral medical facilities).

4 “(2) APPLICATION.—An eligible facility desiring
5 a grant under subsection (a) shall submit to the Sec-
6 retary an application at such time, in such manner,
7 and containing such information as the Secretary
8 may require.

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

12 “(1) the training of health professionals in
13 interdisciplinary, community-based settings that are
14 affiliated with hospitals and other health care facili-
15 ties and teaching institutions;

16 “(2) community development programs that as-
17 sure a diverse health professions workforce through
18 emphasis on individuals from rural and frontier
19 areas and underrepresented minority groups;

20 “(3) the development of a reliable health profes-
21 sions pipeline that provides an emphasis on health-
22 related careers in schools (such as schools partici-
23 pating in the Health Careers Opportunities Pro-
24 gram) and centers of excellence, and that encourage
25 individuals in underrepresented minorities (including

1 Hispanic, African-American, American Indian, and
2 Alaska Native individuals) to pursue health profes-
3 sions careers;

4 “(4) the reduction of health professional isola-
5 tion in rural, frontier, and urban underserved areas
6 through the provision of continuing education, men-
7 toring, and precepting activities, field faculty devel-
8 opment, and the utilization of technology such as
9 telehealth and electronic health records;

10 “(5) the establishment and operation of re-
11 gional or statewide health advice telephone lines to
12 reduce after-hours call responsibilities for over-
13 worked health professionals who provide services in
14 remote areas that have few health professionals tak-
15 ing such after-hours calls;

16 “(6) an increase in the number of professionals
17 taking after-hours calls in hospitals and emergency
18 departments in health professional shortage areas
19 (as defined in section 332), in medically underserved
20 communities (as defined in section 799B), or with
21 respect to medically underserved populations (as de-
22 fined in section 330(b)(3));

23 “(7) the establishment and operation of relief
24 programs that provide health professionals prac-
25 ticing in health professional shortage areas (as de-

1 fined in section 332) with patient and call coverage
2 when such professionals are ill, are pursuing con-
3 tinuing education, or are taking a vacation; and

4 “(8) the exposure of health professions resi-
5 dents to systems of health care that represent the
6 contemporary American healthcare delivery program
7 (such as ‘P4’ Prepare the Personal Physician for
8 Practice and the ‘Health Commons’ programs).

9 “(d) SUBGRANTS.—An eligible facility may use
10 amounts received under a grant under this section to
11 award subgrants to States and other entities determined
12 appropriate by the Secretary to carry out the activities de-
13 scribed in subsection (c).

14 “(e) SET ASIDE.—In awarding grants under this sec-
15 tion, the Secretary shall ensure that a total of \$500,000
16 is awarded annually for the activities of the National
17 Rural Recruitment and Retention Network, or a similar
18 entity.

19 “(f) DEFINITION OF FEDERAL MEDICAL FACIL-
20 ITY.—In this section, the term ‘Federal medical facility’
21 means a facility for the delivery of health services, and
22 includes—

23 “(1) a federally qualified health center (as de-
24 fined in section 330A), a public health center, an

1 outpatient medical facility, or a community mental
2 health center;

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

5 “(3) a migrant health center or an Indian
6 Health Service facility;

7 “(4) a facility for the delivery of health services
8 to inmates in a penal or correctional institution
9 (under section 323) or a State correctional institu-
10 tion;

11 “(5) a Public Health Service medical facility
12 (used in connection with the delivery of health serv-
13 ices under section 320, 321, 322, 324, 325, or
14 326)); or

15 “(6) any other Federal medical facility.

16 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
17 are authorized to be appropriated to carry out this section,
18 \$623,000,000 for fiscal year 2009, \$666,000,000 for fis-
19 cal year 2010, \$675,000,000 for fiscal year 2011,
20 \$700,000,000 for fiscal year 2012, and \$725,000,000 for
21 fiscal year 2013.”.

22 (b) ASSESSMENTS.—

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

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

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

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

20 **SEC. 204. HEALTH PROFESSIONS TRAINING LOAN PRO-**
21 **GRAM.**

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

1 **“SEC. 782. ESTABLISHMENT.**

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

5 “(1) eligible hospitals to enable such hospitals
6 to establish training programs in high-need special-
7 ties; and

8 “(2) eligible non-hospital community-based enti-
9 ties to enable such entities to establish health profes-
10 sions training programs.

11 **“(b) ELIGIBILITY.—**

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

14 “(A) a hospital shall—

15 “(i) be located in a health professional
16 shortage area (as such term is defined in
17 section 332);

18 “(ii) comply with the requirements of
19 paragraph (2); and

20 “(iii) submit to the Secretary an ap-
21 plication at such time, in such manner,
22 and containing such information as the
23 Secretary may require; or

24 “(B) a non-hospital community-based enti-
25 ty shall—

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

3 “(ii) submit to the Secretary an appli-
4 cation at such time, in such manner, and
5 containing such information as the Sec-
6 retary may require.

7 “(2) REQUIREMENTS.—To be eligible to receive
8 a loan under subsection (a), a hospital or non-hos-
9 pital community-based entity shall—

10 “(A) on the date on which the entity sub-
11 mits the loan application, not operate a resi-
12 dency with respect to a high-needs specialty (as
13 determined by the Secretary in consultation
14 with the Permanent National Health Workforce
15 Commission established under section 101(a) of
16 the Health Access and Health Professions Sup-
17 ply Act of 2009) or provide a health professions
18 training program, as the case may be;

19 “(B) have received appropriate preliminary
20 accreditation from the relevant accrediting
21 agency (American Council for Graduate Medical
22 Education, American Osteopathic Association,
23 or Dental, Physician Assistant, Pharmacy, Be-
24 havioral and Mental Health, Public Health, and

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

3 “(C) execute a signed formal contract
4 under which the hospital or entity agree to
5 repay the loan.

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

8 “(1) the salary and fringe benefit expenses of
9 residents, students, trainees, and faculty, or other
10 costs directly attributable to the residency, edu-
11 cational, or training program to be carried out under
12 the loan, as specified by the Secretary; or

13 “(2) facility construction or renovation, includ-
14 ing equipment purchase.

15 “(d) PRIORITY.—In awarding loans under subsection
16 (a), the Secretary shall give priority to applicants that are
17 located in health professional shortage areas (as defined
18 in section 332) or in medically underserved communities
19 (as defined in section 799B), or that serve medically un-
20 derserved populations (as defined in section 330(b)(3)).

21 “(e) LOAN PROVISIONS.—

22 “(1) LOAN CONTRACT.—The loan contract en-
23 tered into under subsection (b)(2) shall contain
24 terms that provide for the repayment of the loan, in-
25 cluding the number and amount of installment pay-

1 ments as described in such contract. Such repay-
 2 ment shall begin on the date that is 24 months after
 3 the date on which the loan contract is executed and
 4 shall be fully repaid not later than 36 months after
 5 the date of the first payment.

6 “(2) INTEREST.—Loans under this section shall
 7 be repaid without interest.

8 “(f) LIMITATION.—The amount of a loan under this
 9 section with respect to each of the uses described in sub-
 10 section (c)(1) or (c)(2) shall not exceed \$2,000,000.

11 “(g) FAILURE TO REPAY.—A hospital or non-hos-
 12 pital community-based entity that fails to comply with the
 13 terms of a contract entered into under subsection (b)(2)
 14 shall be liable to the United States for the amount which
 15 has been paid to such hospital or entity under the con-
 16 tract.

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

20 **SEC. 205. UNITED STATES PUBLIC HEALTH SCIENCES**
 21 **TRACK.**

22 Title II of the Public Health Service Act (42 U.S.C.
 23 202 et seq.) is amended by adding at the end the fol-
 24 lowing:

**“PART D—UNITED STATES PUBLIC HEALTH
SCIENCES TRACK**

“SEC. 271. ESTABLISHMENT.

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

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

“(A) 150 medical students annually;

“(B) 100 dental students annually;

“(C) 250 nursing students annually;

“(D) 100 public health students annually;

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

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

“(G) 50 pharmacy students annually.

“(2) LOCATIONS.—The Track shall be located
at existing and accredited, affiliated health profes-
sions education training programs at academic

1 health centers located in regions of the United
2 States determined appropriate by the Surgeon Gen-
3 eral, in consultation with the Permanent National
4 Health Workforce Commission.

5 “(b) NUMBER OF GRADUATES.—Except as provided
6 in subsection (a), the number of persons to be graduated
7 from the Track shall be prescribed by the Secretary. In
8 so prescribing the number of persons to be graduated from
9 the Track, the Secretary shall institute actions necessary
10 to ensure the maximum number of first-year enrollments
11 in the Track consistent with the academic capacity of the
12 affiliated sites and the needs of the United States for med-
13 ical, dental, and nursing personnel.

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

17 “(d) INTEGRATED LONGITUDINAL PLAN.—The Sur-
18 geon General shall develop an integrated longitudinal plan
19 for health professions continuing education throughout the
20 continuum of health-related education, training, and prac-
21 tice. Training under such plan shall emphasize patient-
22 centered, interdisciplinary, and care coordination skills.
23 Experience with deployment of emergency response teams
24 shall be included during the clinical experiences.

1 “(e) FACULTY DEVELOPMENT.—The Surgeon Gen-
2 eral shall develop faculty development programs and cur-
3 ricula in decentralized venues of health care, to balance
4 urban, tertiary, and inpatient venues.

5 **“SEC. 272. ADMINISTRATION.**

6 “(a) IN GENERAL.—The business of the Track shall
7 be conducted by the Surgeon General with funds appro-
8 priated for and provided by the Department of Health and
9 Human Services. The Permanent National Health Work-
10 force Commission shall assist the Surgeon General in an
11 advisory capacity.

12 “(b) FACULTY.—

13 “(1) IN GENERAL.—The Surgeon General, after
14 considering the recommendations of the Permanent
15 National Health Workforce Commission, shall obtain
16 the services of such professors, instructors, and ad-
17 ministrative and other employees as may be nec-
18 essary to operate the Track, but utilize when pos-
19 sible, existing affiliated health professions training
20 institutions. Members of the faculty and staff shall
21 be employed under salary schedules and granted re-
22 tirement and other related benefits prescribed by the
23 Secretary so as to place the employees of the Track
24 faculty on a comparable basis with the employees of

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

3 “(2) TITLES.—The Surgeon General may con-
4 fer academic titles, as appropriate, upon the mem-
5 bers of the faculty.

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

11 “(c) AGREEMENTS.—The Surgeon General may ne-
12 gotiate agreements with agencies of the Federal Govern-
13 ment to utilize on a reimbursable basis appropriate exist-
14 ing Federal medical resources located in the United States
15 (or locations selected in accordance with section
16 271(a)(2)). Under such agreements the facilities con-
17 cerned will retain their identities and basic missions. The
18 Surgeon General may negotiate affiliation agreements
19 with accredited universities and health professions train-
20 ing institutions in the United States. Such agreements
21 may include provisions for payments for educational serv-
22 ices provided students participating in Department of
23 Health and Human Services educational programs.

1 “(d) PROGRAMS.—The Surgeon General may estab-
2 lish the following educational programs for Track stu-
3 dents:

4 “(1) Postdoctoral, postgraduate, and techno-
5 logical institutes.

6 “(2) A graduate school of nursing.

7 “(3) Other schools or programs that the Sur-
8 geon General determines necessary in order to oper-
9 ate the Track in a cost-effective manner.

10 “(e) CONTINUING MEDICAL EDUCATION.—The Sur-
11 geon General shall establish programs in continuing med-
12 ical education for members of the health professions to
13 the end that high standards of health care may be main-
14 tained within the United States.

15 “(f) AUTHORITY OF THE SURGEON GENERAL.—

16 “(1) IN GENERAL.—The Surgeon General is au-
17 thorized—

18 “(A) to enter into contracts with, accept
19 grants from, and make grants to any nonprofit
20 entity for the purpose of carrying out coopera-
21 tive enterprises in medical, dental, physician as-
22 sistant, pharmacy, behavioral and mental
23 health, public health, and nursing research,
24 consultation, and education;

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

7 “(C) to accept, hold, administer, invest,
8 and spend any gift, devise, or bequest of per-
9 sonal property made to the Track, including
10 any gift, devise, or bequest for the support of
11 an academic chair, teaching, research, or dem-
12 onstration project;

13 “(D) to enter into agreements with entities
14 that may be utilized by the Track for the pur-
15 pose of enhancing the activities of the Track in
16 education, research, and technological applica-
17 tions of knowledge; and

18 “(E) to accept the voluntary services of
19 guest scholars and other persons.

20 “(2) LIMITATION.—The Surgeon General may
21 not enter into any contract with an entity if the con-
22 tract would obligate the Track to make outlays in
23 advance of the enactment of budget authority for
24 such outlays.

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

7 “(4) VOLUNTEER SERVICES.—A person who
 8 provides voluntary services under the authority of
 9 subparagraph (E) of paragraph (1) shall be consid-
 10 ered to be an employee of the Federal Government
 11 for the purposes of chapter 81 of title 5, relating to
 12 compensation for work-related injuries, and to be an
 13 employee of the Federal Government for the pur-
 14 poses of chapter 171 of title 28, relating to tort
 15 claims. Such a person who is not otherwise employed
 16 by the Federal Government shall not be considered
 17 to be a Federal employee for any other purpose by
 18 reason of the provision of such services.

19 **“SEC. 273. STUDENTS; SELECTION; OBLIGATION.**

20 “(a) STUDENT SELECTION.—

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

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

3 “(2) PRIORITY.—In developing admissions pro-
4 cedures under paragraph (1), the Surgeon General
5 shall ensure that such procedures give priority to ap-
6 plicant medical, dental, physician assistant, phar-
7 macy, behavioral and mental health, public health,
8 and nursing students from rural communities and
9 underrepresented minorities.

10 “(b) CONTRACT AND SERVICE OBLIGATION.—

11 “(1) CONTRACT.—Upon being admitted to the
12 Track, a medical, dental, physician assistant, phar-
13 macy, behavioral and mental health, public health,
14 or nursing student shall enter into a written con-
15 tract with the Surgeon General that shall contain—

16 “(A) an agreement under which—

17 “(i) subject to subparagraph (B), the
18 Surgeon General agrees to provide the stu-
19 dent with tuition (or tuition remission) and
20 a student stipend (described in paragraph
21 (2)) in each school year for a period of
22 years (not to exceed 4 school years) deter-
23 mined by the student, during which period
24 the student is enrolled in the Track at an
25 affiliated or other participating health pro-

1 fessions institution pursuant to an agree-
2 ment between the Track and such institu-
3 tion; and

4 “(ii) subject to subparagraph (B), the
5 student agrees—

6 “(I) to accept the provision of
7 such tuition and student stipend to
8 the student;

9 “(II) to maintain enrollment at
10 the Track until the student completes
11 the course of study involved;

12 “(III) while enrolled in such
13 course of study, to maintain an ac-
14 ceptable level of academic standing
15 (as determined by the Surgeon Gen-
16 eral);

17 “(IV) if pursuing a degree from
18 a school of medicine or osteopathic
19 medicine, dental, public health, or
20 nursing school or a physician assist-
21 ant, pharmacy, or behavioral and
22 mental health professional program,
23 to complete a residency or internship
24 in a specialty that the Surgeon Gen-
25 eral determines is appropriate; and

1 “(V) to serve for a period of time
2 (referred to in this part as the ‘period
3 of obligated service’) within the Com-
4 missioned Corps of the Public Health
5 Service equal to 2 years for each
6 school year during which such indi-
7 vidual was enrolled at the College, re-
8 duced as provided for in paragraph
9 (3);

10 “(B) a provision that any financial obliga-
11 tion of the United States arising out of a con-
12 tract entered into under this part and any obli-
13 gation of the student which is conditioned
14 thereon, is contingent upon funds being appro-
15 priated to carry out this part;

16 “(C) a statement of the damages to which
17 the United States is entitled for the student’s
18 breach of the contract; and

19 “(D) such other statements of the rights
20 and liabilities of the Secretary and of the indi-
21 vidual, not inconsistent with the provisions of
22 this part.

23 “(2) TUITION AND STUDENT STIPEND.—

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

1 tions of the Permanent National Health Work-
2 force Commission established under section
3 101(a) of the Health Access and Health Profes-
4 sions Supply Act of 2009, shall establish Fed-
5 eral tuition remission rates to be used by the
6 Track to provide reimbursement to affiliated
7 and other participating health professions insti-
8 tutions for the cost of educational services pro-
9 vided by such institutions to Track students.
10 The agreement entered into by such partici-
11 pating institutions under paragraph (1)(A)(i)
12 shall contain an agreement to accept as pay-
13 ment in full the established remission rate
14 under this subparagraph.

15 “(B) STIPEND.—The Surgeon General,
16 based on the recommendations of the Perma-
17 nent National Health Workforce Commission,
18 shall establish and update Federal stipend rates
19 for payment to students under this part.

20 “(3) REDUCTIONS IN THE PERIOD OF OBLI-
21 GATED SERVICE.—The period of obligated service
22 under paragraph (1)(A)(ii)(V) shall be reduced—

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

1 Health Workforce Commission), by 3 months
2 for each year of such participation (not to ex-
3 ceed a total of 12 months); and

4 “(B) in the case of a student who, upon
5 completion of their residency, elects to practice
6 in a Federal medical facility (as defined in sec-
7 tion 781(e)) that is located in a health profes-
8 sional shortage area (as defined in section 332),
9 by 3 months for year of full-time practice in
10 such a facility (not to exceed a total of 12
11 months).

12 “(c) SECOND 2 YEARS OF SERVICE.—During the
13 third and fourth years in which a medical, dental, physi-
14 cian assistant, pharmacy, behavioral and mental health,
15 public health, or nursing student is enrolled in the Track,
16 training should be designed to prioritize clinical rotations
17 in Federal medical facilities in health professional short-
18 age areas, and emphasize a balance of hospital and com-
19 munity-based experiences, and training within inter-
20 disciplinary teams.

21 “(d) DENTIST, PHYSICIAN ASSISTANT, PHARMACIST,
22 BEHAVIORAL AND MENTAL HEALTH PROFESSIONAL,
23 PUBLIC HEALTH PROFESSIONAL, AND NURSE TRAIN-
24 ING.—The Surgeon General shall establish provisions ap-
25 plicable with respect to dental, physician assistant, phar-

1 macy, behavioral and mental health, public health, and
2 nursing students that are comparable to those for medical
3 students under this section, including service obligations,
4 tuition support, and stipend support. The Surgeon Gen-
5 eral shall give priority to health professions training insti-
6 tutions that train medical, dental, physician assistant,
7 pharmacy, behavioral and mental health, public health,
8 and nursing students for some significant period of time
9 together, but at a minimum have a discrete and shared
10 core curriculum.

11 “(e) ELITE FEDERAL DISASTER TEAMS.—The Sur-
12 geon General, in consultation with the Secretary, the Di-
13 rector of the Centers for Disease Control and Prevention,
14 and other appropriate military and Federal government
15 agencies, shall develop criteria for the appointment of
16 highly qualified Track faculty, medical, dental, physician
17 assistant, pharmacy, behavioral and mental health, public
18 health, and nursing students, and graduates to elite Fed-
19 eral disaster preparedness teams to train and to respond
20 to public health emergencies, natural disasters, bioter-
21 rorism events, and other emergencies.

22 “(f) STUDENT DROPPED FROM TRACK IN AFFILIATE
23 SCHOOL.—A medical, dental, physician assistant, phar-
24 macy, behavioral and mental health, public health, or
25 nursing student who, under regulations prescribed by the

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

5 **“SEC. 274. AUTHORIZATION OF APPROPRIATIONS.**

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

9 **SEC. 206. MEDICAL EDUCATION DEBT REIMBURSEMENT**
10 **FOR PHYSICIANS OF THE VETERANS HEALTH**
11 **ADMINISTRATION.**

12 (a) IN GENERAL.—The Secretary of Veterans Affairs
13 shall carry out a program under which eligible physicians
14 described in subsection (b) are reimbursed for the edu-
15 cation debt of such physicians as described in subsection
16 (c).

17 (b) ELIGIBLE PHYSICIANS.—An eligible physician de-
18 scribed in this subsection is any physician currently ap-
19 pointed to a physician position in the Veterans Health Ad-
20 ministration under section 7402(b)(1) of title 38, United
21 States Code, who enters into an agreement with the Sec-
22 retary to continue serving as a physician in such position
23 for such period of time as the Secretary shall specify in
24 the agreement.

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

10 (d) FREQUENCY OF REIMBURSEMENT.—Any reim-
11 bursement of an eligible physician under this section shall
12 be made in a lump sum or in installments of such fre-
13 quency as the Secretary shall specify the agreement of the
14 physician as required under subsection (b).

15 (e) LIABILITY FOR FAILURE TO COMPLETE OBLI-
16 GATED SERVICE.—Any eligible physician who fails to sat-
17 isfactorily complete the period of service agreed to by the
18 physician under subsection (b) shall be liable to the United
19 States in an amount determined in accordance with the
20 provisions of section 7617(c)(1) of title 38, United States
21 Code.

22 (f) TREATMENT OF REIMBURSEMENT WITH OTHER
23 PAY AND BENEFIT AUTHORITIES.—Any amount of reim-
24 bursement payable to an eligible physician under this sec-
25 tion is in addition to any other pay, allowances, or benefits

1 that may be provided the physician under law, including
 2 any educational assistance under the Department of Vet-
 3 erans Affairs Health Professional Educational Assistance
 4 Program under chapter 76 of title 38, United States Code.

5 **SEC. 207. PROMOTING EDUCATION AND TRAINING OF PSY-**
 6 **CHOLOGISTS TO PROVIDE MENTAL AND BE-**
 7 **HAVIORAL HEALTH SERVICES TO UNDER-**
 8 **SERVED POPULATIONS.**

9 Part E of title VII of the Public Health Service Act
 10 (42 U.S.C. 294n et seq.) is amended by adding at the end
 11 the following:

12 **“Subpart 3—Mental and Behavioral Health Care**
 13 **Workforce**

14 **“SEC. 775. PROGRAM FOR GRADUATE EDUCATION AND**
 15 **TRAINING IN PSYCHOLOGY.**

16 “(a) IN GENERAL.—The Secretary may award
 17 grants, cooperative agreements, and contracts to accred-
 18 ited doctoral, internship, and residency programs in psy-
 19 chology for the development and implementation of pro-
 20 grams to provide interdisciplinary training in integrated
 21 health care settings to students in doctoral psychology
 22 programs, including interns and residents in such pro-
 23 grams. Any training funded by such grants, cooperative
 24 agreements, or contracts shall focus on the needs of under-
 25 served populations.

1 “(b) ELIGIBILITY.—To be eligible to receive an award
2 under this section an entity shall—

3 “(1) provide training at or through an accred-
4 ited doctoral program in psychology, including an in-
5 ternship or residency program; and

6 “(2) prepare and submit to the Secretary an
7 application at such time, in such manner, and con-
8 taining such information as the Secretary may re-
9 quire.

10 “(c) EVALUATION OF PROGRAMS.—The Secretary
11 shall evaluate any program implemented through an
12 award under this section in order to determine the effect
13 of such program on increasing the number of psychologists
14 who provide mental and behavioral health services to un-
15 derserved populations.

16 “(d) DEFINITIONS.—For purposes of this section—

17 “(1) the term ‘underserved population’ means
18 individuals, especially older adults, children, chron-
19 ically ill individuals, victims of abuse or trauma, and
20 victims of combat- or war-related stress disorders,
21 including post-traumatic stress disorder and trau-
22 matic brain injury, and their families, living in an
23 urban or rural area that has a shortage of mental
24 or behavioral health services; and

1 “(2) the term ‘interdisciplinary training’ means
2 training for graduate psychology students with 1 or
3 more of the other health professions, including medi-
4 cine, nursing, dentistry, and pharmacy.

5 “(e) AUTHORIZATION OF APPROPRIATIONS.—To
6 carry out this section, there is authorized to be appro-
7 priated \$10,000,000 for fiscal year 2010, \$12,000,000 for
8 fiscal year 2011, \$14,000,000 for fiscal year 2012,
9 \$16,000,000 for fiscal year 2013, and \$18,000,000 for fis-
10 cal year 2014.”.

11 **TITLE III—HEALTH PROFES-**
12 **SIONAL TRAINING PIPELINE**
13 **PARTNERSHIPS PROGRAM**

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

16 (a) PURPOSE.—The purpose of this section is to sup-
17 port the development and implementation of programs de-
18 signed to prepare middle school and high school students
19 for study and careers in the healthcare field, including
20 success in postsecondary mathematics and science pro-
21 grams.

22 (b) DEFINITIONS.—In this section:

23 (1) CHILDREN FROM LOW-INCOME FAMILIES.—
24 The term “children from low-income families”
25 means children described in section 1124(c)(1)(A) of

1 the Elementary and Secondary Education Act of
2 1965 (20 U.S.C. 6333(c)(1)(A)).

3 (2) ELIGIBLE RECIPIENTS.—The term “eligible
4 recipient” means—

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

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

9 (i) not less than 1 institution of high-
10 er education with an established health
11 profession education program; and

12 (ii) not less than 1 community-based,
13 private sector healthcare provider organiza-
14 tion.

15 (3) HIGH-NEED LOCAL EDUCATIONAL AGEN-
16 CY.—The term “high-need local educational agency”
17 means a local educational agency or educational
18 service agency—

19 (A) that serves not fewer than 10,000 chil-
20 dren from low-income families;

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

24 (C) that meets the eligibility requirements
25 for funding under the Small, Rural School

1 Achievement Program under section 6211(b) of
2 the Elementary and Secondary Education Act
3 of 1965 (20 U.S.C. 7345(b)); or

4 (D) that meets the eligibility requirements
5 for funding under the Rural and Low-Income
6 School Program under section 6221(b)(1) of
7 the Elementary and Secondary Education Act
8 of 1965 (20 U.S.C. 7351(b)(1)).

9 (4) NONPROFIT HEALTHCARE CAREER PATH-
10 WAY PARTNERSHIP ORGANIZATION.—The term
11 “nonprofit healthcare career pathway partnership
12 organization” means a nonprofit organization fo-
13 cused on developing career and educational pathways
14 to healthcare professions, that shall include rep-
15 resentatives of—

16 (A) the local educational agencies;

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

22 (C) not less than 1 community-based, pri-
23 vate sector healthcare provider organization or
24 other healthcare industry organization.

1 (5) SECRETARY.—The term “Secretary” means
2 the Secretary of Education.

3 (c) GRANTS AUTHORIZED.—

4 (1) IN GENERAL.—The Secretary is authorized
5 to award grants, on a competitive basis, to eligible
6 recipients to enable the recipients to develop and im-
7 plement programs of study to prepare middle school
8 and high school students for postsecondary edu-
9 cation leading to careers in the healthcare field.

10 (2) MINIMUM FUNDING LEVEL.—Grants shall
11 be awarded at a minimum level of \$500,000 per re-
12 cipient, per year.

13 (3) RENEWABILITY.—Grants may be renewed,
14 at the discretion of the Secretary, for not more than
15 5 years.

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

22 (e) PRIORITY.—In awarding grants under this sec-
23 tion, the Secretary shall give priority to—

24 (1) applicants that include a local educational
25 agency that is located in an area that is designated

1 under section 332(a)(1)(A) of the Public Health
2 Service Act (42 U.S.C. 254e(a)(1)(A)) as a health
3 professional shortage area;

4 (2) applicants that include an institution of
5 higher education that emphasizes an interdiscipli-
6 nary approach to health profession education; and

7 (3) applicants whose program involves the de-
8 velopment of a uniquely innovative public-private
9 partnership.

10 (f) AUTHORIZED ACTIVITIES/USE OF FUNDS.—

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

16 (A) are aligned with State challenging aca-
17 demic content standards and State challenging
18 student academic achievement standards; and

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

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

24 (ii) necessary to enter healthcare jobs
25 directly.

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

3 (A) involve a review and identification of
4 the content knowledge and skills students who
5 enter institutions of higher education and the
6 workforce need to have in order to succeed in
7 the healthcare field;

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

13 (C) include an outreach component to edu-
14 cate middle school and high school students and
15 their parents about the full range of employ-
16 ment opportunities in the healthcare field, spe-
17 cifically in the local community;

18 (D) include specific opportunities for youth
19 to interact with healthcare professionals or in-
20 dustry representatives in the classroom, school,
21 or community locations and how these experi-
22 ences will be integrated with coursework;

23 (E) include high-quality volunteer or in-
24 ternship experiences, integrated with
25 coursework;

1 (F) provide high-quality mentoring, coun-
2 seling, and career counseling support services to
3 program participants;

4 (G) consider the inclusion of a distance-
5 learning component or similar education tech-
6 nology that would expand opportunities for geo-
7 graphically isolated individuals;

8 (H) encourage the participation of individ-
9 uals who are members of groups that are
10 underrepresented in postsecondary education
11 programs in mathematics and science;

12 (I) encourage participants to seek work in
13 communities experiencing acute health profes-
14 sional shortages; and

15 (J) collect data, and analyze the data
16 using measurable objectives and benchmarks, to
17 evaluate the extent to which the program suc-
18 ceeded in—

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

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

1 (iii) increasing the number of students
2 entering health care professions upon grad-
3 uation; and

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

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

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

17 (h) REPORTS.—

18 (1) ANNUAL EVALUATION.—Each eligible re-
19 cipient that receives a grant under this section shall
20 collect and report to the Secretary annually such in-
21 formation as the Secretary may reasonably require,
22 including—

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

1 (B) the race, gender, socio-economic sta-
2 tus, and disability status of program partici-
3 pants;

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

6 (D) the number of program participants
7 who reported enrollment in some form of post-
8 secondary education with the potential to lead
9 to a career in the healthcare field;

10 (E) the number of program participants
11 who entered a paid position, either part-time or
12 full-time, in the healthcare field following par-
13 ticipation in the program; and

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

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

20 (i) AUTHORIZATION AND APPROPRIATION.—

21 (1) IN GENERAL.—There are authorized to be
22 appropriated \$100,000,000 for each of fiscal years
23 2009 through 2013 to carry out this section.

24 (2) ADMINISTRATIVE COSTS.—For the costs of
25 administering this section, including the costs of

1 evaluating the results of grants and submitting re-
2 ports to the Congress, there are authorized to be ap-
3 propriated such sums as may be necessary for each
4 of fiscal years 2009 through 2013.

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