To improve access to and the quality of primary health care, expand the health workforce, and for other purposes.

IN THE SENATE OF THE UNITED STATES

Mr. Sanders (for himself and Mr. Marshall) introduced the following bill; which was read twice and referred to the Committee on

A BILL

To improve access to and the quality of primary health care, expand the health workforce, and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) Short Title.—This Act may be cited as the “Bipartisan Primary Care and Health Workforce Act”.

(b) Table of Contents.—The table of contents for this Act is as follows:
Sec. 1. Short title; table of contents.

TITLE I—EXTENSION FOR COMMUNITY HEALTH CENTERS, THE NATIONAL HEALTH SERVICE CORPS, AND TEACHING HEALTH CENTERS THAT OPERATE GME PROGRAMS

Sec. 101. Programs of payments to teaching health centers that operate graduate medical education programs.
Sec. 102. Community health centers.
Sec. 103. National Health Service Corps.
Sec. 104. GAO report.
Sec. 105. OIG report.
Sec. 106. Application of provisions.

TITLE II—SUPPORTING THE HEALTH CARE WORKFORCE

Sec. 201. Rural residency planning and development program.
Sec. 202. Primary care training and enhancement program.
Sec. 203. Telehealth technology-enabled learning program.
Sec. 204. Expanding the number of primary care doctors.
Sec. 205. Nurse education, practice, quality, and retention grants.
Sec. 206. Nurse faculty loan program.
Sec. 207. Nurse faculty demonstration program.
Sec. 208. Nurse corps scholarship and loan repayment program.
Sec. 209. Grants for primary care nurse residency training programs.
Sec. 210. State oral health workforce improvement grant program.
Sec. 211. Oral health training programs.
Sec. 212. Allied health professionals.
Sec. 213. Budgetary treatment.

TITLE III—REDUCING HEALTH CARE COSTS FOR PATIENTS

Sec. 301. Banning anticompetitive terms in facility and insurance contracts that limit access to higher quality, lower cost care.
Sec. 302. Honest billing requirements applicable to providers.
Sec. 303. Banning facility fees for certain services.
Sec. 304. Prevention and Public Health Fund.
TITLE I—EXTENSION FOR COMMUNITY HEALTH CENTERS, THE NATIONAL HEALTH SERVICE CORPS, AND TEACHING HEALTH CENTERS THAT OPERATE GME PROGRAMS

SEC. 101. PROGRAMS OF PAYMENTS TO TEACHING HEALTH CENTERS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.

(a) FUNDING.—Section 340H(g)(1) of the Public Health Service Act (42 U.S.C. 256h(g)(1)) is amended—

(1) by striking “such sums as may be necessary, not to exceed”;

(2) by striking “2017, and” and inserting “2017,”; and

(3) by inserting “and $300,000,000 for each of fiscal years 2024 through 2028,” after “2023,”.

(b) PER RESIDENT AMOUNT.—Section 340H(a)(2) of the Public Health Service Act (42 U.S.C. 256h(a)(2)) is amended by adding at the end the following: “Beginning in fiscal year 2024, in accordance with paragraph (1), but notwithstanding the capped amount referenced in subsections (b)(2) and (d)(2), the qualified teaching health center per resident amount for a fiscal year shall be not less than such amount for the previous fiscal year.”.
(c) AMOUNT OF PAYMENTS.—Section 340H of the Public Health Service Act (42 U.S.C. 256h) is amended—

(1) in subsection (b)(2)—

(A) in subparagraph (A), by striking “amount of funds appropriated under subsection (g) for such payments for that fiscal year” and inserting “total amount of funds available under subsection (g) and any amounts recouped under subsection (f)”;

(B) in subparagraph (B), by striking “appropriated in a fiscal year under subsection (g)” and inserting “available under subsection (g) and any amounts recouped under subsection (f)”;

(2) in subsection (d)(2)(B), by striking “amount appropriated for such expenses as determined in subsection (g)” and inserting “total amount of funds available under subsection (g) and any amounts recouped under subsection (f)”.

(d) PRIORITY PAYMENTS.—Section 340H(a)(3) of Public Health Service Act (42 U.S.C. 256h(a)(3)) is amended—

(1) in subparagraph (A), by striking “; or” and inserting a semicolon;
(2) in subparagraph (B), by striking the period and inserting “; or”; and

(3) by adding at the end the following:

“(C) are located in a State that does not already have a qualified teaching health center receiving funding under this section.”.

(e) Reporting Requirements.—Section 340H(h)(1) of the Public Health Service Act (42 U.S.C. 256h(h)(1)) is amended—

(1) by redesignating subparagraph (H) as subparagraph (I); and

(2) by inserting after subparagraph (G) the following:

“(H) Of the number of residents described in paragraph (4) who completed their residency training, the number practicing primary care (meaning any of the areas of practice listed in the definition of a primary care residency program in section 749A) 5 years following completion of such training.”.

(f) Guidance.—The Secretary shall update guidance and relevant information regarding States described in subparagraph (C) of section 340H(a)(3) of the Public Health Service Act (42 U.S.C. 256h(a)(3)), as amended by subsection (d), and make available model templates to
assist health centers in such States to establish a teaching health center.

SEC. 102. COMMUNITY HEALTH CENTERS.

(a) Community Health Center Fund.—Section 10503 of the Patient Protection and Affordable Care Act (42 U.S.C. 254b–2) is amended—

(1) in subsection (b)(1)(F)—

(A) by striking “‘2018 and’” and inserting “‘2018,’”; and

(B) by inserting before the semicolon the following: “, and $5,800,000,000 for each of fiscal years 2024 through 2026”; and

(2) by adding at the end the following:

“(f) Priority Use of Funds.—For fiscal years 2024 through 2026, with respect to $1,800,000,000 of the amount appropriated under subsection (b)(1)(F), the Secretary shall prioritize awards to entities for purposes of—

“(1) increasing the number of low-income patients not enrolled in a group health plan or group or individual health insurance coverage who are served by health centers, including through Health Center Program New Access Points described in section 330(e)(6) of the Public Health Service Act, including school-based service sites;
“(2) increasing the required primary health services described in paragraph (1)(A)(i) of section 330(b) of the Public Health Service Act and additional health services (as defined in paragraph (2) of such section) offered by health centers; and

“(3) increasing patient case management, enabling services, and education services, as described in clauses (iii) through (v) of section 330(b)(1)(A) of the Public Health Service Act.”.

(b) Authorization of Appropriations.—Section 330(r)(1) of the Public Health Service Act (42 U.S.C. 254b(r)(1)) is amended—

(1) in subparagraph (G), by striking “fiscal year 2016, and each subsequent fiscal year” and inserting “each of fiscal years 2016 through 2023”;

and

(2) by adding at the end the following:

“(H) For each of fiscal years 2024 through 2026, $2,200,000,000.

“(I) For fiscal year 2027, and each subsequent fiscal year, the amount appropriated for the preceding fiscal year adjusted by the product of—
“(i) one plus the average percentage increase in costs incurred per patient served; and

“(ii) one plus the average percentage increase in the total number of patients served.”.

(c) ALLOCATION OF FUNDS.—Section 10503 of the Patient Protection and Affordable Care Act (42 U.S.C. 254b–2), as amended by subsection (a), is further amended by adding at the end the following:

“(g) ALLOCATION OF FUNDS.—For each of fiscal years 2024 through 2026, of the amounts appropriated under subsection (b)(1)(F) for a fiscal year, the Secretary shall use—

“(1) at least $245,000,000 for awards to support health centers in each State that are receiving awards under section 330 of the Public Health Service Act in extending operating hours, in an amount determined pursuant to a formula and eligibility criteria developed by the Secretary, for the purposes of increasing access to services;

“(2) at least $55,000,000 for awards under this section for health centers to expand school-based services and establish new school-based service sites; and
“(3) such sums as may be necessary for purposes of increasing the amount awarded pursuant to grants or cooperative agreements under section 330 of the Public Health Service Act so that each recipient of such an award receives—

“(A) for fiscal year 2024, at least 15 percent more than such recipient received for fiscal year 2023; and

“(B) for each of fiscal years 2025 and 2026, the amount received in the previous year adjusted by—

“(i) the percent increase in the medical component of the consumer price index for the most recent 12-month period for which applicable data is available; plus

“(ii) one percent.”.

(d) CAPITAL FUNDING.—Section 10503(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 254b–2(c)) is amended—

(1) in the subsection heading, by inserting “, CAPITAL FUNDING” after “CONSTRUCTION”;

(2) by striking “There is” and inserting the following:

“(1) CONSTRUCTION.—There is”; and

(3) by adding at the end the following:
“(2) CAPITAL FUNDING.—For the alteration, renovation, construction, equipment, and other capital costs of health centers that receive funding under section 330 of the Public Health Service Act (42 U.S.C. 254b), in addition to amounts otherwise made available for such purpose, there is appropriated to the Secretary of Health and Human Services, out of amounts in the Treasury not otherwise appropriated, $3,000,000,000 for fiscal year 2024, to remain available until September 30, 2026. In awarding amounts appropriated under this paragraph, the Secretary shall prioritize awards related to increasing access to dental and behavioral health services.”.

(e) STRATEGIC PLAN TO IMPROVE HEALTH OUTCOMES THROUGH NUTRITION.—

(1) IN GENERAL.—Not later than one year after the date of enactment of this Act, the Secretary of Health and Human Services, in consultation with the Secretary of Agriculture, shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a 5-year strategic plan to improve health outcomes through nutrition for low-income or uninsured pa-
tient populations with severe, complex chronic condi-
tions and one or more diet-related conditions.

(2) REPORT.—In carrying out paragraph (1),
the Secretary of Health and Human Services shall—
(A) conduct an evaluation of previous and
current federally-funded efforts of the Depart-
ment of Health and Human Services to improve
patient outcomes through nutrition interven-
tions, such as medically-tailored meals and nu-
trition counseling; and
(B) include in the strategic report rec-
ommendations for—
(i) reducing the financial impact of
obesity and preventable chronic conditions
resulting from obesity;
(ii) empowering federally-funded com-
community health centers, rural health clinics,
and other relevant federally-funded facili-
ties to provide produce prescriptions, medi-
cally-tailored groceries, and medically-tai-
lored meals;
(iii) promoting long-term adoption of
improved nutrition habits, including
through increased culinary education and
consumer nutrition aligned with the most
recent Dietary Guidelines for Americans published under section 301 of the National Nutrition Monitoring and Related Research Act of 1990 (7 U.S.C. 5341) and incorporating behavioral modeling or other novel methods across Federal programs;

(iv) developing performance and quality metrics related to the delivery of produce prescriptions, medically-tailored groceries, and medically-tailored meals across relevant Federal payers to aid in reimbursement strategies;

(v) developing payment models for novel obesity care therapies for the treatment of diabetes that include behavioral and nutritional and dietary services and education;

(vi) improving coordination of care and integrating nutrition services and resources within federally-funded community health centers, rural health clinics, and other federally-funded primary care facilities;
(vii) bolstering partnerships with State and local governments and non-
governmental organizations; and

(viii) addressing geographic disparities in access to nutrition services and re-
sources.

(f) REQUIRED PRIMARY HEALTH SERVICES.—

(1) IN GENERAL.—Section 330 of the Public Health Service Act (42 U.S.C. 254b) is amended—

(A) in subsection (b)(1)(A)—

(i) in clause (i)—

(I) in subclause (IV), by striking “; and” and inserting a semicolon;

(II) in subclause (V), by adding “and” after the semicolon; and

(III) by adding at the end the following:

“(VI) appropriate nutritional and dietary services;”;

(ii) in clause (ii), by inserting “and nutrition services” after “mental health services”; and

(iii) in clause (iii), by inserting “nutri-
tional,” after “educational,”; and
(B) in subsection (d)(1)(A), by inserting “or one or more diet-related conditions” before the semicolon.

(2) Implementation of new required primary health service.—Paragraph (4) of section 330(e) of the Public Health Service Act (42 U.S.C. 254b(e)) is amended to read as follows:

“(4) Limitation.—Not more than 2 grants may be made under paragraph (1)(B) for the same entity, except that such limitation shall not apply for the period of 2 years beginning on the date of enactment of the Bipartisan Primary Care and Health Workforce Act, in any case where the only basis upon which paragraph (1)(B) applies to a health center is that the health center is not in noncompliance with the requirements under subsection (b)(1)(A)(i)(VI) to provide appropriate nutritional and dietary services.”.

(g) Increase the use of provider tools to improve health outcomes.—Not later than one year after the date of enactment of this Act, the Secretary of Health and Human Services, in consultation with the Secretary of Agriculture, shall submit to Congress a report that includes—
(1) recommendations for States to support the coordination of federally-funded nutrition programs and services provided by health care professionals in community health centers; and

(2) data on the number of individuals enrolled in federally-subsidized health insurance coverage who are also enrolled in or eligible for federally-subsidized nutrition and food programs.

SEC. 103. NATIONAL HEALTH SERVICE CORPS.

Section 10503(b)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 254b–2(b)(2)) is amended—

(1) in subparagraph (G), by striking “; and” and inserting a semicolon;

(2) in subparagraph (H), by striking the period and inserting “; and”;

(3) by adding at the end the following:

“(I) $950,000,000 for each of fiscal years 2024 through 2026.”.

SEC. 104. GAO REPORT.

(a) IN GENERAL.—Not later than one year after the date of enactment of this Act, the Comptroller General of the United States shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House
of Representatives a report assessing the effectiveness of
the National Health Service Corps (referred to in this sec-
tion as the “NHSC”) at attracting health care profes-
sionals to health professional shortage areas designated
under section 332 of the Public Health Service Act (42
U.S.C. 254e) (referred to in this section as “HPSAs”),
such as by—

(1) assessing the metrics used by the Health
Resources and Services Administration in evaluating
the program;

(2) comparing the retention rates of NHSC
participants in the HPSAs where they completed
their period of obligated service to the retention rate
of non-NHSC participants in the corresponding
HPSAs;

(3) comparing the retention rates of NHSC
participants in the HPSAs where they completed
their period of obligated service to the retention
rates of NHSC participants in HPSAs other than
those where they completed their period of obligated
service;

(4) identifying factors that influence a NHSC
participant’s decision to practice in a HPSA other
than the HPSA where they completed their period of
obligated service;
(5) identifying factors other than participation in the National Health Service Corps Scholarship and Loan Repayment Programs that attract health care professionals to a HPSA;

(6) assessing the impact the NHSC has on wages for health care professionals in a HPSA; and

(7) comparing the distribution of NHSC participants across HPSAs, including a comparison of rural versus non-rural HPSAs.

(b) DEFINITION.—In this section, the term “NHSC participant” means a National Health Service Corps member participating in the National Health Service Corps Scholarship or Loan Repayment Program under subpart III of part D of title III of the Public Health Service Act (42 U.S.C. 254l et seq.).

SEC. 105. OIG REPORT.

Not later than 2 years after the date of enactment of this Act, the Inspector General of the Department of Health and Human Services shall submit to Congress a report on integrity efforts of the Health Resources and Services Administration with respect to programs carried out by the Health Resources and Services Administration. Such report shall include an assessment of—

(1) the ways in which the Administrator of the Health Resources and Services Administration (re-
ferred to in this section as the “Administrator”) determines reasonable efforts are continuously made to establish and maintain collaborative relationships with health care providers;

(2) the ways in which the Administrator ensures quality and continuity of care for underserved areas; and

(3) the extent to which the Administrator validates the financial responsibility of and use of grant funding by community health centers.

SEC. 106. APPLICATION OF PROVISIONS.

(a) IN GENERAL.—Amounts appropriated pursuant to the amendments made by this title shall be subject to the requirements contained in Public Law 117-328 for funds for programs authorized under sections 330 through 340 of the Public Health Service Act (42 U.S.C. 254b through 256).

(b) CONFORMING AMENDMENT.—Paragraph (4) of section 3014(h) of title 18, United States Code, “and section 301(d) of division BB of the Consolidated Appropriations Act, 2021.” and inserting “section 301(d) of division BB of the Consolidated Appropriations Act, 2021, and section 106(a) of the Bipartisan Primary Care and Health Workforce Act”.
TITLE II—SUPPORTING THE HEALTH CARE WORKFORCE

SEC. 201. RURAL RESIDENCY PLANNING AND DEVELOPMENT PROGRAM.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by inserting after section 330A–2 the following:

“SEC. 330A–3. RURAL RESIDENCY PLANNING AND DEVELOPMENT PROGRAM AND RURAL RESIDENCY PLANNING AND DEVELOPMENT TECHNICAL ASSISTANCE PROGRAM.

“(a) Definition of Rural Residency Program.—In this section, the term ‘rural residency program’ means a physician residency program, including a rural track program, accredited by the Accreditation Council for Graduate Medical Education (or a similar body) that—

“(1) trains residents in rural areas (as defined by the Secretary) for more than 50 percent of the total time of their residency; and

“(2) primarily focuses on producing physicians who will practice in rural areas, as defined by the Secretary.

“(b) Rural Residency Planning and Development Program.—
“(1) Definition of eligible entity.—In this subsection, the term ‘eligible entity’—

“(A) means—

“(i) a domestic public or private nonprofit or for-profit entity;

“(ii) an Indian Tribe, Tribal health program, Tribal organization, or Urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act); or

“(iii) a Native Hawaiian Health organization as defined in section 12 of the Native Hawaiian Health Care Improvement; and

“(B) may include faith-based or community-based organizations, rural hospitals, rural community-based ambulatory patient care centers (including rural health clinics), health centers operated by a Native Hawaiian Health organization (defined as described in subparagraph (A)(iii)), an Indian Tribe, a Tribal health program, a Tribal organization, or an Urban Indian organization (defined as described in subparagraph (A)(ii)), graduate medical education consortia
higher education, such as schools of allopathic medicine, schools of osteopathic medicine, or historically Black colleges or universities (as defined by the term ‘part B institution’ in section 322 of the Higher Education Act of 1965 or described in section 326(e)(1) of the Higher Education Act of 1965) or other minority-serving institutions (as described in section 371(a) of the Higher Education Act of 1965), or other organizations as determined appropriate by the Secretary.

“(2) GRANTS.—

“(A) IN GENERAL.—The Secretary may award grants to eligible entities to create new rural residency programs (including adding new rural training sites to existing rural track programs).

“(B) FUNDING.—Grants awarded under this subsection may be fully funded at the time of the award.

“(C) TERM.—The term of a grant under this subsection shall be 4 years and may be extended at the discretion of the Secretary.

“(3) APPLICATIONS.—
“(A) IN GENERAL.—To be eligible to receive a grant under this subsection, an eligible entity shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the pathway of the rural residency program as described in subparagraph (B).

“(B) PATHWAY.—A pathway of a rural residency program supported under this subsection shall be for—

“(i) general primary care and high-need specialty care, including family medicine, internal medicine, preventive medicine, psychiatry, or general surgery;

“(ii) maternal health and obstetrics, which may be obstetrics and gynecology or family medicine with enhanced obstetrical training; or

“(iii) any other pathway as determined appropriate by the Secretary.

“(c) RURAL RESIDENCY PLANNING AND DEVELOPMENT TECHNICAL ASSISTANCE.—

“(1) DEFINITION OF ELIGIBLE ENTITY.—In this subsection, the term ‘eligible entity’ means—
“(A) a domestic public or private nonprofit or for-profit entity; or

“(B) an Indian Tribe or Tribal organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act).

“(2) GRANTS.—

“(A) IN GENERAL.—The Secretary may award grants to eligible entities to provide technical assistance to awardees of and potential applicants of the program described in subsection (b).

“(B) FUNDING.—Grants awarded under this subsection may be fully funded at the time of the award.

“(C) TERM.—The term of a grant under this subsection shall be 4 years and may be extended at the discretion of the Secretary.

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

“(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $13,000,000 for fiscal year 2024, $13,500,00 for fiscal
year 2025, and $14,000,000 for fiscal year 2026, to remain available until expended.”.

SEC. 202. PRIMARY CARE TRAINING AND ENHANCEMENT PROGRAM.

Section 747(c)(1) of the Public Health Service Act (42 U.S.C. 293k(c)(1)) is amended—

(1) by striking “$48,924,000 for each of fiscal years 2021 through 2025” and inserting “$49,250,000 for fiscal year 2024, $49,500,000 for fiscal year 2025, and $50,000,000 for fiscal year 2026”; and

(2) by striking “subsection (b)(1)(B)” and inserting “subsections (b)(1)(B) and (c)”.

SEC. 203. TELEHEALTH TECHNOLOGY-ENABLED LEARNING PROGRAM.

Section 330N(k) of the Public Health Service Act (42 U.S.C. 254c–20(k)) is amended by striking “2026” and inserting “2025, and $11,000,000 for each of fiscal years 2026 through 2028, to remain available until expended”.

SEC. 204. EXPANDING THE NUMBER OF PRIMARY CARE DOCTORS.

Section 747 of the Public Health Service Act (42 U.S.C. 293k), as amended by section 202, is further amended—
(1) by redesignating subsection (c) as subsection (d); and

(2) by inserting after subsection (b) the following:

“(c) EXPANDING THE NUMBER OF PRIMARY CARE DOCTORS.—

“(1) IN GENERAL.—The Secretary shall award grants to eligible medical schools described in paragraph (2) for the purpose of graduating more physicians who will practice a primary care discipline. Funds awarded under this subsection may be used for costs associated with faculty, construction and capital improvements, clinical support, research support, student supports, and any other costs, as determined by the Secretary.

“(2) ELIGIBILITY.—To be eligible to receive a grant under this subsection, a medical school shall—

“(A) be a nonprofit school of medicine or osteopathic medicine that is accredited by a nationally recognized accrediting agency or association; and

“(B) demonstrate in the grant application of the medical school—

“(i) that not less than 33 percent of graduates from the medical school enter
primary care and are, as of the date of the application, practicing primary care, as calculated by dividing—

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“(I) the number of physicians who graduated during such time period as is specified by the Secretary who are practicing primary care; by
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“(II) the total number of physicians who graduated during such time period; and
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“(ii) a plan to expand the number of graduates of the medical school who are practicing primary care; and
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“(iii) a commitment to use grant funds to supplement, not supplant, such school’s investment in primary care medical education.
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“(3) Expanding the number of minority primary care doctors.—Of the amounts appropriated under paragraph (6)(C), the Secretary shall awards not less than 20 percent to eligible medical schools described in paragraph (2) that are historically Black colleges and universities (as defined by the term ‘part B institution’ in section 322 of the Higher Education Act of 1965 (20 U.S.C. 1061) or
described in section 326(e)(1) of such Act (20 U.S.C. 1063b(e)(1))) or other minority-serving institutions (as described in section 371(a) of the Higher Education Act of 1965 (20 U.S.C. 1067q(a))).

“(4) GRANT AMOUNTS; GEOGRAPHIC DISTRIBUTION.—

“(A) GRANT AMOUNTS.—The Secretary shall determine the amount of each grant awarded under this subsection, which shall be based on the scope of the plan submitted by the medical school under paragraph (2)(B)(ii), and other appropriate factors.

“(B) GEOGRAPHIC DISTRIBUTION.—In awarding grants under this subsection, the Secretary shall ensure, to the greatest extent practicable, that such grants are equitably distributed among the geographic regions of the United States.

“(5) PRIMARY CARE.—In this subsection, the term ‘primary care’ means health care services related to family medicine, internal medicine, pediatrics, obstetrics, gynecology, geriatrics, or psychiatry.

“(6) ACCOUNT TO ADDRESS THE PRIMARY CARE PHYSICIAN SHORTAGE.—
“(A) Establishment of Account.—
There is established in the Treasury an account, to be known as the ‘Account to Address the Primary Care Physician Shortage’ (referred to in this subsection as the ‘Account’), for purposes of carrying out this subsection.

“(B) Transfer of Direct Spending.—

“(i) In general.—The Secretary of the Treasury shall transfer, from the general fund of the Treasury, to the Account $300,000,000 for fiscal year 2024.

“(ii) Amounts deposited.—Any amounts transferred under clause (i) shall remain unavailable in the Account until such amounts are appropriated pursuant to subparagraph (C).

“(C) Appropriations.—

“(i) Authorization of appropriations.—For the period of fiscal years 2024 through 2026, there is authorized to be appropriated from the Account to the Secretary, for the purpose of carrying out the activities under this subsection, an amount not to exceed the total amount
transferred to the Account under subpara-
ograph (B)(i).

“(ii) Offsetting future appropriations.—For fiscal years 2024
through 2026, for any discretionary appro-
piation under the heading ‘Account to Ad-
dress the Primary Care Physician Short-
age’ provided to the Secretary pursuant to
the authorization of appropriations under
clause (i) for the purpose of carrying out
this subsection, the total amount of such
appropriations for the applicable fiscal year
(not to exceed the total amount remaining
in the Account) shall be subtracted from
the estimate of discretionary budget au-
authority and the resulting outlays for any
estimate under the Congressional Budget
and Impoundment Control Act of 1974 or
the Balanced Budget and Emergency Def-
cit Control Act of 1985, and the amount
transferred to the Account shall be reduced
by the same amount.

“(7) Annual reports.—Not later than Octo-
ber 1 of fiscal years 2025 through 2027, the Sec-
retary shall submit to the Committee on Health,
Education, Labor, and Pensions and the Committee on Appropriations of the Senate and the Committee on Energy and Commerce and the Committee on Appropriations of the House of Representatives, a report including a description of any use of funds provided pursuant to the authorization of appropriations under paragraph (6)(C).

“(8) LIMITATIONS.—Notwithstanding any transfer authority authorized by this subsection or any appropriations Act, any funds made available pursuant to the authorization of appropriations under paragraph (6)(C) may not be used for any purpose other than the program established under paragraph (1).

“(9) SUNSET.—Amounts remaining unappropriated in the Account under this subsection shall be transferred back to the general fund of the Treasury on October 1, 2026.”.

SEC. 205. NURSE EDUCATION, PRACTICE, QUALITY, AND RETENTION GRANTS.

(a) REAUTHORIZATION.—Section 831 of the Public Health Service Act (42 U.S.C. 296p) is amended by adding at the end the following:

“(g) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section (other than subsection (e)), in addi-
tion to amounts made available under section 871(a), there are authorized to be appropriated $59,413,000 for each of fiscal years 2024 through 2026, to remain available until expended.”.

(b) **Expanding Associate Degree Nursing Programs.**—Section 831 of the Public Health Service Act (42 U.S.C. 296p), as amended by subsection (a), is further amended—

(1) by redesignating subsections (e) through (g) as subsections (f) through (h), respectively; and

(2) by inserting after subsection (d) the following:

“(e) **Supplemental Appropriations Expanding Associate Degree Nursing Programs.**—

“(1) **Authorization.**—The Secretary shall award grants to institutions of higher education (as defined in section 101 of the Higher Education Act of 1965) offering an accredited registered nursing program at the associate degree level for the purpose of expanding the number of students enrolled in each such program.

“(2) **Use of Funds.**—A recipient of a grant under this subsection shall use the grant funds to expand the number of students enrolled in the recipient’s accredited registered nursing program,
which may include increasing nurse faculty and
nurse faculty salaries, expanding the number of
qualified preceptors at clinical rotations sites, pro-
viding direct support for students, supporting part-
nerships with health facilities for clinical training,
purchasing and training faculty to use distance
learning technologies and simulation equipment, al-
teration, renovation, construction, equipment, and
other capital improvement costs, and other projects
determined appropriate by the Secretary.

“(3) Determination of Number of Students and Application.—Each institution of
higher education that offers a program described in
paragraph (1) that desires to receive a grant under
this subsection shall—

“(A) provide documentation from the last
4 academic years, or number of academic years
the program has been accredited if less than 4,
demonstrating the average percentage of indi-
viduals who graduated from the nursing degree
program with an associate degree within 150
percent of the expected completion time des-
ignated for the program; and

“(B) submit an application to the Sec-
retary at such time, in such manner, and ac-
compounded by such information as the Secretary
may require, including the average percent of
individuals determined under subparagraph (A).

“(4) DEFINITION.—For purposes of this sub-
section, the term ‘health facility’ means an Indian
health service center, a Native Hawaiian health cen-
ter, a Federally qualified health center, a rural
health clinic, a nursing home, a home health agency,
a hospice program, a public health clinic, a State or
local department of public health, a skilled nursing
facility, or an ambulatory surgical center.

“(5) ACCOUNT TO ADDRESS THE NURSING
WORKFORCE SHORTAGE.—

“(A) ESTABLISHMENT OF ACCOUNT.—
There is established in the Treasury an ac-
count, to be known as the ‘Account to Address
the Nursing Workforce Shortage’ (referred to in
this subsection as the ‘Account’), for purposes
of carrying out this subsection, in addition to
amounts otherwise made available, including
under section 871(a).

“(B) TRANSFER OF DIRECT SPENDING.—

“(i) IN GENERAL.—The Secretary of
the Treasury shall transfer, from the gen-
eral fund of the Treasury, to the Account
$240,000,000 for each of fiscal years 2024 through 2028.

“(ii) Amounts deposited.—Any amounts transferred under clause (i) shall remain unavailable in the Account until such amounts are appropriated pursuant to subparagraph (C).

“(C) Appropriations.—

“(i) Authorization of appropriations.—For each of fiscal years 2024 through 2028, there is authorized to be appropriated from the Account to the Secretary, for the purpose of carrying out the activities under this subsection, in addition to amounts otherwise made available for such purpose, an amount not to exceed the total amount transferred to the Account under subparagraph (B)(i).

“(ii) Offsetting future appropriations.—For any of fiscal years 2024 through 2028, for any discretionary appropriation under the heading ‘Account to Address the Nursing Workforce Shortage’ provided to the Secretary pursuant to the authorization of appropriations under
clause (i) for an additional amount for carrying out this subsection, the total amount of such appropriations for the applicable fiscal year (not to exceed the total amount remaining in the Account) shall be subtracted from the estimate of discretionary budget authority and the resulting outlays for any estimate under the Congressional Budget and Impoundment Control Act of 1974 or the Balanced Budget and Emergency Deficit Control Act of 1985, and the amount transferred to the Account shall be reduced by the same amount.

“(6) ANNUAL REPORTS.—Not later than October 1 of fiscal years 2025 through 2029, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Appropriations of the Senate and the Committee on Energy and Commerce and the Committee on Appropriations of the House of Representatives, a report including a description of any use of funds provided pursuant to the authorization of appropriations under paragraph (5)(C).

“(7) LIMITATIONS.—Notwithstanding any transfer authority authorized by this subsection or
any appropriations Act, any funds made available pursuant to the authorization of appropriations under paragraph (5)(C) may not be used for any purpose other than the program established under paragraph (1).

“(8) SUNSET.—Amounts remaining unappropriated in the Account under this subsection shall be transferred back to the general fund of the Treasury on October 1, 2028.”.

SEC. 206. NURSE FACULTY LOAN PROGRAM.

Section 846A of the Public Health Service Act (42 U.S.C. 297n–1), as amended by section 207, is amended by inserting after subsection (b) the following:

“(c) FUNDING.—

“(1) AUTHORIZATION OF APPROPRIATIONS.—

“(A) IN GENERAL.—To carry out this section (other than subsection (d)), in addition to amounts otherwise made available, including under section 871(b) and paragraph (2), there are authorized to be appropriated $28,500,000 for each of fiscal years 2024 through 2026, to remain available until expended.

“(2) ACCOUNT TO ADDRESS THE NURSE FACULTY WORKFORCE SHORTAGE.—
“(A) Establishment of Account.—

There is established in the Treasury an account, to be known as the ‘Account to Address the Nurse Faculty Shortage’ (referred to in this paragraph as the ‘Account’), for purposes of carrying out this section (other than subsection (d)) in addition to amounts otherwise made available, including under section 871(b) and paragraph (1).

“(B) Transfer of Direct Spending.—

“(i) In general.—The Secretary of the Treasury shall transfer, from the general fund of the Treasury, to the Account $57,000,000 for each of fiscal years 2024 through 2026.

“(ii) Amounts deposited.—Any amounts transferred under clause (i) shall remain unavailable in the Account until such amounts are appropriated pursuant to subparagraph (C).

“(C) Appropriations.—

“(i) Authorization of Appropriations.—For each of fiscal years 2024 through 2026, there is authorized to be appropriated from the Account to the Sec-
retary, for the purpose of carrying out the
activities under this section, in addition to
amounts otherwise made available for such
purpose, an amount not to exceed the total
amount transferred to the Account under
subparagraph (B)(i).

“(ii) OFFSETTING FUTURE APPROPRIATIONS.—For any of fiscal years 2024
through 2026, for any discretionary appropriation under the heading ‘Account to Ad-
dress the Nurse Faculty Shortage’ pro-
vided to the Secretary pursuant to the au-
thorization of appropriations under clause
(i) for an additional amount for carrying
out this section, the total amount of such
appropriations for the applicable fiscal year
(not to exceed the total amount remaining
in the Account) shall be subtracted from
the estimate of discretionary budget au-
thority and the resulting outlays for any
estimate under the Congressional Budget
and Impoundment Control Act of 1974 or
the Balanced Budget and Emergency Def-
icit Control Act of 1985, and the amount
transferred to the Account shall be reduced by the same amount.

“(D) ANNUAL REPORTS.—Not later than October 1 of fiscal years 2025 through 2027, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Appropriations of the Senate and the Committee on Energy and Commerce and the Committee on Appropriations of the House of Representatives, a report including a description of any use of funds provided pursuant to the authorization of appropriations under subparagraph (C).

“(E) LIMITATIONS.—Notwithstanding any transfer authority authorized by this paragraph or any appropriations Act, any funds made available pursuant to the authorization of appropriations under subparagraph (C) may not be used for any purpose other than the program under this section.

“(F) SUNSET.—Amounts remaining unappropriated in the Account under this paragraph shall be transferred back to the general fund of the Treasury on October 1, 2026.”.
SEC. 207. NURSE FACULTY DEMONSTRATION PROGRAM.

Section 846A of the Public Health Service Act (42 U.S.C. 297n–1) is amended—

(1) by amending subsection (a) to read as follows:

“(a) IN GENERAL.—To increase the number of qualified nursing faculty, the Secretary may—

“(1) enter into an agreement with any accredited school of nursing for the establishment and operation of a student loan fund in accordance with subsection (b); and

“(2) award nurse faculty grants in accordance with subsection (d).”;

(2) in subsection (b)—

(A) by redesignating subparagraphs (A) through (D) of paragraph (2) as clauses (i) through (iv), respectively, and adjusting the margins accordingly;

(B) by redesignating paragraphs (1) through (5) as subparagraphs (A) through (E), respectively, and adjusting the margins accordingly;

(C) in subparagraph (C), as so redesignated, by striking “subsection (e)” and inserting “paragraph (2)”;

...
(D) by striking “(b) AGREEMENTS—Each agreement entered into under subsection (a) shall—” and inserting the following:

“(b) SCHOOL OF NURSING STUDENT LOAN FUND.—
“(1) IN GENERAL.—Each agreement entered into under subsection (a)(1) shall—”.

(3) in subsection (e)—

(A) by striking “subsection (a)” each place it appears and inserting “subsection (a)(1)”;

(B) in paragraph (3), by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively, and adjusting the margins accordingly;

(C) in paragraph (6), by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively, and adjusting the margins accordingly;

(D) by redesignating paragraphs (1) through (6) as subparagraphs (A) through (F), respectively, and adjusting the margins accordingly; and

(E) in subparagraph (F)(ii), as so redesignated, by striking “subsection (e)” and inserting “paragraph (4)”;
(4) in subsection (e), by striking “subsection (e)(6)(B)” and inserting “paragraph (2)(F)(ii)”;

(5) by redesignating subsections (c) through (e) (before application of the amendment made by section 206) as paragraphs (2) through (4), respectively, and adjusting the margins accordingly; and

(6) by adding after subsection (c), as added by section 206, the following:

“(d) Nurse Faculty Demonstration Program.—

“(1) In general.—The Secretary shall establish and carry out a demonstration program described in subsection (a)(2) under which eligible schools of nursing receive a grant for purposes of supplementing the salaries of eligible nursing faculty members to enhance recruitment and retention of nursing faculty members.

“(2) Eligible Entities.—To be eligible to receive a grant under this subsection, an entity shall—

“(A) be an accredited school of nursing;

and

“(B) submit an application to the Secretary, at such time, in such manner, and containing such information as the Secretary may require, including—
“(i)(I) to the extent such information is available to the school of nursing, the salary history of nursing faculty at such school who previously were nurses in clinical practice, for the most recent 3-year period ending on the date of application, adjusted for inflation as appropriate and broken down by credentials, experience, and levels of education of such nurses; or

“(II) if the information described in subclause (I) is not available, information on the average local salary of nurses in clinical practice, adjusted for inflation as appropriate and broken down by credentials, experience, and levels of education of the individual nurses, in accordance with such requirements as the Secretary may specify;

“(ii) an attestation of the average nursing faculty salary at the school of nursing during the most recent 3-year period prior to the date of application, adjusted for inflation, as appropriate, broken
down by credentials, experience, and levels of education of such faculty members;

“(iii) the number of nursing faculty member vacancies at the entity at the time of application, and the entity’s projection of such vacancies over the ensuing 5-year period; and

“(iv) a description of the entity’s plans to identify funding sources to sustainably continue, after the 2-year grant period, the salary available to the eligible nursing faculty member pursuant to the program under this subsection during such grant program and to retain eligible nursing faculty members after the end of the grant period.

“(3) AWARDS.—A grant awarded under this subsection, with respect to supporting eligible nursing faculty members, shall—

“(A) be awarded to the school of nursing to supplement the salaries of eligible faculty members at the school of nursing, annually, for up to a 2-year period, in an amount equal to, for each eligible nursing faculty member at the
eligible entity during the grant period, the difference between—

“(i) the average salary of nurses in clinical practice submitted under subclause (I) or (II) of paragraph (2)(B)(i); and

“(ii) the greater of—

“(I) the salary for the eligible nursing faculty member at the school of nursing; or

“(II) the average nursing faculty salary submitted under paragraph (2)(B)(ii) for faculty members with the same or similar credentials and level of education;

“(B) notwithstanding section 803(a), be used in its entirety to supplement the eligible faculty member’s salary; and

“(C) be conditioned upon the school of nursing maintaining, for each year in which the award is made as described in subparagraph (A), a salary for such faculty member at a level that is not less than the greater of the amount under subclause (I) or (II) of subparagraph (A)(ii).
“(4) PRIORITY.—In awarding grants under this subsection, the Secretary shall ensure the equitable geographic distribution of awards, and shall give priority to applications from schools of nursing that demonstrate—

“(A) the greatest need for such grant, which may be based upon the financial circumstances of the school of nursing, eligible nurse faculty members, the planned number of students to be trained or admitted off a wait list;

“(B) training or partnerships to serve vulnerable patient populations, such as through the location or activity of a school in a health professional shortage area (as defined in section 332);

“(C) recruitment and retention of faculty from underrepresented populations; or

“(D) other particular need for such grant, including public institutions of higher education that offer 4-year degrees but at which the predominant degree awarded is an associate degree.

“(5) RULE OF CONSTRUCTION.—Nothing in this subsection precludes a school of nursing or an
eligible nursing faculty member receiving an award under this section from obtaining or receiving any other form of Federal support or funding.

“(6) REPORT.—Not later than 3 years after the date of enactment of the Bipartisan Primary Care and Health Workforce Act, the Secretary shall submit to the Committee on Finance and the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives, a report that evaluates the program established under this subsection, including—

“(A) the impact of such program on recruitment and retention rates of nursing faculty, as available, and specifically for each faculty member participating in the program; and

“(B) recommendations and considerations for Congress on continuing the program under this subsection.

“(7) DEFINITIONS.—In this subsection:

“(A) ELIGIBLE NURSING FACULTY MEMBER.—The term ‘eligible nursing faculty member’ means a nursing faculty member who—
“(i) was hired by a school of nursing within the 2-year period preceding the submission of an application under paragraph (2), or a prospective nursing faculty member;

“(ii) is currently employed at the school of nursing and who demonstrates the need for such support;

“(iii) previously worked as a nurse in clinical practice or as a nurse faculty member at another school of nursing; or

“(iv) may work on a part-time basis as a nursing faculty member, for whom such award amounts described in paragraph (3) shall be prorated relative to the amount of time participating in part-time teaching.

“(B) INFLATION.—The term ‘inflation’ means the Consumer Price Index for all urban consumers (all items; U.S. city average).

“(8) AUTHORIZATION OF APPROPRIATIONS.—To carry out this subsection, in addition to amounts otherwise available, including under section 871(b), there is authorized to be appropriated $15,000,000 for each of fiscal years 2024 and 2025.”.
SEC. 208. NURSE CORPS SCHOLARSHIP AND LOAN REPAYMENT PROGRAM.

Section 846 of the Public Health Service Act (42 U.S.C. 297n) is amended by adding at the end the following:

“(j) Authorization of Appropriations.—To carry out this section, in addition to amounts otherwise made available, including under section 871(b), there are authorized to be appropriated $93,600,000 for fiscal year 2024, $94,600,000 for fiscal year 2025, and $95,600,000 for fiscal year 2026, to remain available until expended.”.

SEC. 209. GRANTS FOR PRIMARY CARE NURSE RESIDENCY TRAINING PROGRAMS.

Section 5316 of the Patient Protection and Affordable Care Act (42 U.S.C. 296j–1) is amended—

(1) in the section heading, by striking “DEMONSTRATION”;

(2) in subsection (a), by striking “demonstration”;

(3) in subsection (d)—

(A) in paragraph (1)(B), by striking “and” at the end;

(B) by redesignating paragraph (2) as paragraph (3); and

(C) by inserting after paragraph (1) the following:
“(2)(A) in the case of an entity that does not have an established residency program for nurse practitioners at the time of the application, demonstrate plans to establish a new residency program for nurse practitioners; or

“(B) in the case of an entity that has an established residency program for nurse practitioners at the time of the application, demonstrate plans to use the grant under this section to offer not fewer than 4 additional residency positions for new nurse practitioners to participate in such program; and”;

(4) in subsection (i), by striking “such sums as may be necessary for each of fiscal years 2011 through 2014” and inserting “$30,000,000 for each of fiscal years 2024 through 2026”.

SEC. 210. STATE ORAL HEALTH WORKFORCE IMPROVEMENT GRANT PROGRAM.

Subsection (f) of section 340G of the Public Health Service Act (42 U.S.C. 256g) is amended by striking “$13,903,000 for each of fiscal years 2019 through 2023” and inserting “$15,200,000 for fiscal year 2024, $15,500,000 for fiscal year 2025, and $15,800,000 for fiscal year 2026, to remain available until expended”.
SEC. 211. ORAL HEALTH TRAINING PROGRAMS.

Subsection (f) of section 748 of the Public Health Service Act (42 U.S.C. 293k–2) is amended to read as follows:

“(f) Authorization of Appropriations.—

“(1) In general.—To carry out this section, there is authorized to be appropriated $28,500,000 for fiscal year 2026, to remain available until expended.

“(2) Geographic distribution.—In awarding grants under this section, the Secretary shall ensure, to the greatest extent practicable, that such grants are equitably distributed among the geographical regions of the United States.”.

SEC. 212. ALLIED HEALTH PROFESSIONALS.

(a) Supporting Dual or Concurrent Enrollment in the Allied Health Projects Program.—

Section 755(b)(1) of the Public Health Service Act (42 U.S.C. 294e(b)(1)) is amended—

(1) in subparagraph (B), by striking “to individuals who have baccalaureate degrees in health-related sciences”;

(2) in the flush text at the end of subparagraph (I), by striking “; and” and inserting a semicolon;

(3) in subparagraph (J), by striking the period and inserting “; and”; and
(4) by adding at the end the following:

“(K) those that establish or support a dual or concurrent enrollment program (as defined in section 8101 of the Elementary and Secondary Education Act of 1965) if the dual or concurrent enrollment program—

“(i) provides outreach on allied health careers requiring an industry-recognized credential, a certificate, or an associate degree, to all high schools served by the local educational agency that is a partner in the partnership offering the dual or concurrent enrollment program;

“(ii) provides information to high school students about the training requirements and expected salary of allied health professions; and

“(iii) provides academic and financial aid counseling to students who participate in the dual or concurrent enrollment program.”.

(b) Supporting Dual or Concurrent Enrollment in the Health Careers Opportunity Program.—Section 739(a)(2) of the Public Health Service Act (42 U.S.C. 293e(a)(2)) is amended—
(1) in subparagraph (H), by striking “and” after the semicolon;
(2) in subparagraph (I), by striking the period at the end and inserting “; and”; and
(3) by adding at the end the following:

“(J) providing academic and financial aid counseling to support participation in a dual or concurrent enrollment program (as defined in section 8101 of the Elementary and Secondary Education Act of 1965) that leads to an industry-recognized credential, a certificate, or an associate degree in the health professions or academic credits that can be transferred, as indicated through an articulation agreement between 2 or more community colleges or universities, to obtain an industry-recognized credential, a certificate, or a degree in the health professions.”.

(c) Health Care Workforce Innovation Program.—Section 755(b) of the Public Health Service Act (42 U.S.C. 294e(b)) is amended by adding at the end the following:

“(5)(A) Supporting and developing new innovative, community-driven approaches for the education and training of allied health professionals, including
those described in subparagraph (F)(i), with an emphasis on expanding the supply of such professionals located in, and meeting the needs of, underserved communities and rural areas. Grants under this paragraph shall be awarded through a new program (referred to as the ‘Health Care Workforce Innovation Program’ or in this paragraph as the ‘Program’).

“(B) To be eligible to receive a grant under the Program an entity shall—

“(i) be a Federally qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act), a State-level association or other consortium that represents and is comprised of Federally qualified health centers, or a certified rural health clinic that meets the requirements of section 334; and

“(ii) submit to the Secretary an application that, at a minimum, contains—

“(I) a description of how all trainees will be trained in accredited training programs either directly or through partnerships with public or nonprofit private entities;
“(II) a description of the community-driven health care workforce innovation model to be carried out under the grant, including the specific professions to be funded;

“(III) the geographic service area that will be served, including quantitative data, if available, showing that such particular area faces a shortage of health professionals and lacks access to health care;

“(IV) a description of the benefits provided to each health care professional trained under the proposed model during the education and training phase;

“(V) a description of the experience that the applicant has in the recruitment, retention, and promotion of the well-being of workers and volunteers;

“(VI) a description of how the funding awarded under the Program will supplement rather than supplant existing funding;

“(VII) a description of the scalability and replicability of the community-driven approach to be funded under the Program;
“(VIII) a description of the infrastructure, outreach and communication plan and other program support costs required to operationalize the proposed model; and

“(IX) any other information, as the Secretary determines appropriate.

“(C)(i) An entity shall use amounts received under a grant awarded under the Program to carry out the innovative, community-driven model described in the application under subparagraph (B). Such amounts may be used for launching new or expanding existing innovative health care professional partnerships, including the following specific uses:

“(I) Establishing or expanding a partnership between an eligible entity and 1 or more high schools, accredited public or nonprofit private vocational-technical schools, accredited public or nonprofit private 2-year colleges, area health education centers, and entities with clinical settings for the provision of education and training opportunities not available at the grantee’s facilities.

“(II) Providing education and training programs to improve allied health professionals’
readiness in settings that serve underserved communities and rural areas; encouraging students from underserved and disadvantaged backgrounds and former patients to consider careers in health care, and better reflecting and meeting community needs; providing education and training programs for individuals to work in patient-centered, team-based, community-driven health care models that include integration with other clinical practitioners and training in cultural and linguistic competence; providing pre-apprenticeship and apprenticeship programs for health care technical, support, and entry-level occupations, particularly for those enrolled in dual or concurrent enrollment programs; building a preceptorship training-to-practice model for medical, behavioral health, oral health, and public health disciplines in an integrated, community-driven setting; providing and expanding internships, career ladders, and development opportunities for health care professionals, including new and existing staff; or investing in training equipment, supplies, and limited renovations or retrofitting of training
space needed for grantees to carry out their particular model.

“(ii) Amounts received under a grant awarded under the Program shall not be used to support construction costs or to supplant funding from existing programs that support the applicant’s health workforce.

“(iii) Models funded under the Program shall be for a duration of at least 3 years.

“(D) In awarding grants under the Program, the Secretary may give priority to applicants that will use grant funds to support workforce innovation models that increase the number of individuals from underserved and disadvantaged backgrounds working in such health care professions, improve access to health care (including medical, behavioral health and oral health) in underserved communities, or demonstrate that the model can be replicated in other underserved communities in a cost-efficient and effective manner to achieve the purposes of the Program.

“(E) An entity that receives a grant under the Program shall provide periodic reports to the Secretary detailing the findings and outcomes of the innovative, community-driven model carried out under
the grant. Such reports shall contain information in a manner and at such times as determined appropriate by the Secretary.

“(F) In this paragraph:

“(i) The term ‘allied health care professional’ includes individuals who provide clinical support services, including medical assistants, dental assistants, dental hygienists, pharmacy technicians, physical therapists and health care interpreters; individuals providing non-clinical support, such as billing and coding professionals and health information technology professionals; dieticians; medical technologists; emergency medical technicians; community health workers; public health personnel; and peer support workers.

“(ii) The term ‘rural area’ has the meaning given such term by the Administrator of the Health Resources and Services Administration.

“(iii) The term ‘underserved communities’ means areas, population groups, and facilities designated as health professional shortage areas under section 332, medically underserved areas as defined under section 330I(a)), or medically
underserved populations as defined under section 330(b)(3).

“(G)(i) There are authorized to be appropriated $100,000,000 for each of fiscal years 2024 through 2026, to carry out this section, to remain available until expended.

“(ii) A grant provided under the Program shall not exceed $2,500,000 for a grant period.”.

SEC. 213. BUDGETARY TREATMENT.

(a) Statutory PayGO Scorecards.—The budgetary effects of section 302 (including the amendments made by such section), up to $1,671,000,000, shall not be entered on either PAYGO scorecard maintained pursuant to section 4(d) of the Statutory Pay As-You-Go Act of 2010 (2 U.S.C. 933(d)).

(b) Senate PayGO Scorecards.—The budgetary effects of section 302 (including the amendments made by such section), up to $1,671,000,000, shall not be entered on any PAYGO scorecard maintained for purposes of section 4106 of H. Con. Res. 71 (115th Congress).

(c) Reservation of Savings.—None of the funds in the Account to Address the Primary Care Physician Shortage (established under section 747(c)(6) of the Public Health Service Act, as amended by section 204), the Account to Address the Nursing Workforce Shortage (es-
established under section 831(e)(5) of the Public Health Service Act, as amended by section 205), or the Account to Address the Nurse Faculty Shortage (established under section 846A(c)(2) of the Public Health Service Act, as amended by section 206) shall be made available except to the extent provided in advance in appropriations Acts, and legislation or an Act that rescinds or reduces amounts in such accounts shall not be estimated as a reduction in direct spending under the Congressional Budget and Impoundment Control Act of 1974 or the Balanced Budget and Emergency Deficit Control Act of 1985.

**TITLE III—REDUCING HEALTH CARE COSTS FOR PATIENTS**

**SEC. 301. BANNING ANTICOMPETITIVE TERMS IN FACILITY AND INSURANCE CONTRACTS THAT LIMIT ACCESS TO HIGHER QUALITY, LOWER COST CARE.**

(a) In General.—

(1) Public health service act.—Section 2799A–9 of the Public Health Service Act (42 U.S.C. 300gg–119) is amended—

(A) by adding at the end the following:

“‘(b) Protecting Health Plans Network Design Flexibility.—
“(1) IN GENERAL.—A group health plan or a health insurance issuer offering group or individual health insurance coverage shall not enter into an agreement with a provider, network or association of providers, or other service provider offering access to a network of service providers if such agreement, directly or indirectly—

“(A) restricts the group health plan or health insurance issuer from—

“(i) directing or steering enrollees to other health care providers; or

“(ii) offering incentives to encourage enrollees to utilize specific health care providers; or

“(B) requires the group health plan or health insurance issuer to enter into any additional contract with an affiliate of the provider as a condition of entering into a contract with such provider;

“(C) requires the group health plan or health insurance issuer to agree to payment rates or other terms for any affiliate not party to the contract of the provider involved; or

“(D) restricts other group health plans or health insurance issuers not party to the con-
tract from paying a lower rate for items or services than the contracting plan or issuer pays for such items or services.

“(2) ADDITIONAL REQUIREMENT FOR SELF-INSURED PLANS.—A self-insured group health plan shall not enter into an agreement with a provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers if such agreement directly or indirectly requires the group health plan to certify, attest, or otherwise confirm in writing that the group health plan is bound by restrictive contracting terms between the service provider and a third-party administrator that the group health plan is not party to, without a disclosure that such terms exist.

“(3) EXCEPTION FOR PLANS AND ISSUERS.—Paragraph (1)(A) shall not apply to a group health plan or health insurance issuer offering group or individual health insurance coverage with respect to—

“(A) a health maintenance organization (as defined in section 2791(b)(3)), if such health maintenance organization operates primarily through exclusive contracts with multi-specialty physician groups, nor to any arrange-
ment between such a health maintenance organ-
ization and its affiliates; or

“(B) a value-based network arrangement,
such as an exclusive provider network, account-
able care organization, center of excellence, a
provider sponsored health insurance issuer that
operates primarily through aligned multi-spe-
cialty physician group practices or integrated
health systems, or such other similar network
arrangements as determined by the Secretary
through rulemaking.

“(4) ATTESTATION.—A group health plan or
health insurance issuer offering group or individual
health insurance coverage shall annually submit to,
as applicable, the applicable authority described in
section 2723 or the Secretary of Labor or the Sec-
retary of the Treasury, an attestation that such plan
or issuer is in compliance with the requirements of
this subsection.

“(5) RULE OF CONSTRUCTION.—Nothing in
this subsection shall be construed to limit network
design or cost or quality initiatives by a group health
plan or health insurance issuer, including account-
able care organizations, exclusive provider organiza-
tions, networks that tier providers by cost or quality
or steer enrollees to centers of excellence, or other
pay-for-performance programs.

“(6) COMPLIANCE WITH RESPECT TO ANTI-
TRUST LAWS.—Compliance with this subsection does
not constitute compliance with the antitrust laws, as
defined in subsection (a) of the first section of the
Clayton Act (15 U.S.C. 12(a)).

“(7) GRANDFATHERING.—An applicable State
authority may make a determination that the prohi-
bitions under paragraph (1) (with respect to condi-
tions that would direct or steer to, or offer incentives
to encourage enrollees to use, other health care pro-
viders) will not apply in the State with respect to
any specified agreement that is executed before the
date of enactment of the Bipartisan Primary Care
and Health Workforce Act, for a maximum length of
nonapplicability of up to 10 years from the date of
execution of the contract if the applicable State au-
thority determines that the contract is unlikely to
significantly lessen competition. With respect to a
specified agreement for which an applicable State
authority has made a determination under the pre-
ceding sentence an applicable State authority may
determine whether renewal of the contract, within
the applicable 10-year period, is allowed.”; and
(B) by redesignating paragraph (5) of subsection (a) as subsection (e), adjusting the margin of such subsection accordingly, and transferring such subsection (e) to appear after subsection (b), as added by subparagraph (A).


(A) by adding at the end the following:

“(b) PROTECTING HEALTH PLANS NETWORK DESIGN FLEXIBILITY.—

“(1) In general.—A group health plan or a health insurance issuer offering group health insurance coverage shall not enter into an agreement with a provider, network or association of providers, or other service provider offering access to a network of service providers if such agreement, directly or indirectly—

“(A) restricts the group health plan or health insurance issuer from—

“(i) directing or steering enrollees to other health care providers; or
“(ii) offering incentives to encourage enrollees to utilize specific health care providers; or

“(B) requires the group health plan or health insurance issuer to enter into any additional contract with an affiliate of the provider as a condition of entering into a contract with such provider;

“(C) requires the group health plan or health insurance issuer to agree to payment rates or other terms for any affiliate not party to the contract of the provider involved; or

“(D) restricts other group health plans or health insurance issuers not party to the contract from paying a lower rate for items or services than the contracting plan or issuer pays for such items or services.

“(2) ADDITIONAL REQUIREMENT FOR SELF-INSURED PLANS.—A self-insured group health plan shall not enter into an agreement with a provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers if such agreement directly or indirectly requires the group health plan to certify, attest, or otherwise confirm in writing that the
group health plan is bound by restrictive contracting
terms between the service provider and a third-party
administrator that the group health plan is not
party to, without a disclosure that such terms exist.

“(3) EXCEPTION FOR PLANS AND ISSUERS.—

Paragraph (1)(A) shall not apply to a group health
plan or health insurance issuer offering group health
insurance coverage with respect to—

“(A) a health maintenance organization
(as defined in section 733(b)(3)), if such health
maintenance organization operates primarily
through exclusive contracts with multi-specialty
physician groups, nor to any arrangement be-
tween such a health maintenance organization
and its affiliates; or

“(B) a value-based network arrangement,
such as an exclusive provider network, account-
able care organization, center of excellence, a
provider sponsored health insurance issuer that
operates primarily through aligned multi-spe-
cialty physician group practices or integrated
health systems, or such other similar network
arrangements as determined by the Secretary
through rulemaking.
“(4) ATTESTATION.—A group health plan or health insurance issuer offering group health insurance coverage shall annually submit to, as applicable, the applicable authority described in section 2723 of the Public Health Service Act or the Secretary of Labor or the Secretary of the Treasury, an attestation that such plan or issuer is in compliance with the requirements of this subsection.

“(5) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to limit network design or cost or quality initiatives by a group health plan or health insurance issuer, including accountable care organizations, exclusive provider organizations, networks that tier providers by cost or quality or steer enrollees to centers of excellence, or other pay-for-performance programs.

“(6) COMPLIANCE WITH RESPECT TO ANTI-TRUST LAWS.—Compliance with this subsection does not constitute compliance with the antitrust laws, as defined in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)).

“(7) GRANDFATHERING.—An applicable State authority may make a determination that the prohibitions under paragraph (1) (with respect to conditions that would direct or steer to, or offer incentives
to encourage enrollees to use, other health care providers) will not apply in the State with respect to any specified agreement that is executed before the date of enactment of the Bipartisan Primary Care and Health Workforce Act, for a maximum length of nonapplicability of up to 10 years from the date of execution of the contract if the applicable State authority determines that the contract is unlikely to significantly lessen competition. With respect to a specified agreement for which an applicable State authority has made a determination under the preceding sentence an applicable State authority may determine whether renewal of the contract, within the applicable 10-year period, is allowed.”; and

(B) by redesignating paragraph (4) of subsection (a) as subsection (c), adjusting the margin of such subsection accordingly, and transferring such subsection (c) to appear after subsection (b), as added by subparagraph (A).

(3) INTERNAL REVENUE CODE OF 1986.—Section 9824 of the Internal Revenue Code of 1986 is amended—

(A) by adding at the end the following:

“(b) PROTECTING HEALTH PLANS NETWORK DESIGN FLEXIBILITY.—
“(1) IN GENERAL.—A group health plan shall not enter into an agreement with a provider, network or association of providers, or other service provider offering access to a network of service providers if such agreement, directly or indirectly—

“(A) restricts the group health plan from—

“(i) directing or steering enrollees to other health care providers; or

“(ii) offering incentives to encourage enrollees to utilize specific health care providers; or

“(B) requires the group health plan to enter into any additional contract with an affiliate of the provider as a condition of entering into a contract with such provider;

“(C) requires the group health plan to agree to payment rates or other terms for any affiliate not party to the contract of the provider involved; or

“(D) restricts other group health plans not party to the contract from paying a lower rate for items or services than the contracting plan pays for such items or services.
“(2) ADDITIONAL REQUIREMENT FOR SELF-INSURED PLANS.—A self-insured group health plan shall not enter into an agreement with a provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers if such agreement directly or indirectly requires the group health plan to certify, attest, or otherwise confirm in writing that the group health plan is bound by restrictive contracting terms between the service provider and a third-party administrator that the group health plan is not party to, without a disclosure that such terms exist.

“(3) EXCEPTION FOR CERTAIN PLANS.—Paragraph (1)(A) shall not apply to a group health plan with respect to—

“(A) a health maintenance organization (as defined in section 9832(b)(3)), if such health maintenance organization operates primarily through exclusive contracts with multi-specialty physician groups, nor to any arrangement between such a health maintenance organization and its affiliates; or

“(B) a value-based network arrangement, such as an exclusive provider network, accountable care organization, center of excellence, a
provider sponsored health insurance issuer that 
operates primarily through aligned multi-spe-
cialty physician group practices or integrated 
health systems, or such other similar network 
arrangements as determined by the Secretary 
through rulemaking.

“(4) ATTESTATION.—A group health plan shall 
annually submit to, as applicable, the applicable au-
thority described in section 2723 of the Public 
Health Service Act or the Secretary of Labor or the 
Secretary of the Treasury, an attestation that such 
plan is in compliance with the requirements of this 
subsection.

“(5) RULE OF CONSTRUCTION.—Nothing in 
this subsection shall be construed to limit network 
design or cost or quality initiatives by a group health 
plan, including accountable care organizations, ex-
clusive provider organizations, networks that tier 
providers by cost or quality or steer enrollees to cen-
ters of excellence, or other pay-for-performance pro-
grams.

“(6) COMPLIANCE WITH RESPECT TO ANTI-
TRUST LAWS.—Compliance with this subsection does 
not constitute compliance with the antitrust laws, as
defined in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)).

“(7) GRANDFATHERING.—An applicable State authority may make a determination that the prohibitions under paragraph (1) (with respect to conditions that would direct or steer to, or offer incentives to encourage enrollees to use, other health care providers) will not apply in the State with respect to any specified agreement that is executed before the date of enactment of the Bipartisan Primary Care and Health Workforce Act, for a maximum length of nonapplicability of up to 10 years from the date of execution of the contract if the applicable State authority determines that the contract is unlikely to significantly lessen competition. With respect to a specified agreement for which an applicable State authority has made a determination under the preceding sentence an applicable State authority may determine whether renewal of the contract, within the applicable 10-year period, is allowed.”; and

(B) by redesignating paragraph (4) of subsection (a) as subsection (c), adjusting the margin of such subsection accordingly, and transferring such subsection (c) to appear after subsection (b), as added by subparagraph (A).
(b) Regulations.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury, jointly, shall promulgate regulations to carry out section 2799A–9(b) of the Public Health Service Act, section 724(b) of the Employee Retirement Income Security Act of 1974, and section 9824(b) of the Internal Revenue Code of 1986, as added by subsection (a).

(c) Effective Date.—Subsection (b) of section 2799A–9 of the Public Health Service Act, subsection (b) of section 724 of the Employee Retirement Income Security Act of 1974, and subsection (b) of section 9824 of the Internal Revenue Code of 1986 (as added by paragraphs (1), (2), and (3), respectively, of subsection (a)) shall apply with respect to any contract entered into on or after the date that is 18 months after the date of enactment of this Act. With respect to an applicable contract that is in effect on the date of enactment of this Act, such subsection (b) shall apply on the earlier of the date of renewal of such contract or 3 years after such date of enactment.
SEC. 302. HONEST BILLING REQUIREMENTS APPLICABLE TO PROVIDERS.

(a) Group Health Plan and Health Insurance Issuer Requirements.—

(1) Public Health Service Act.—Part D of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–111 et seq.) is amended by adding at the end the following:

“SEC. 2799A–11. HONEST BILLING REQUIREMENTS APPLICABLE TO PLANS AND ISSUERS.

“A group health plan or health insurance issuer offering group or individual health insurance coverage may not pay a claim for items and services furnished on or after January 1, 2026, to an individual at an off-campus outpatient department of a provider (as defined in section 2799B–10(b))) submitted by a health care provider or facility unless such claim submitted by such provider or facility includes a separate unique health identifier for the department where items and services were furnished, in accordance with section 2799B–10.”.

(2) Employee Retirement Income Security Act of 1974.—

(A) In general.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185...
et seq.) is amended by adding at the end the following:

“SEC. 726. HONEST BILLING REQUIREMENTS APPLICABLE TO PLANS AND ISSUERS.

“A group health plan or health insurance issuer offering group health insurance coverage may not pay a claim for items and services furnished on or after January 1, 2026, to an individual at an off-campus outpatient department of a provider (as defined in section 2799B–10(b)) of the Public Health Service Act) submitted by a health care provider or facility unless such claim submitted by such provider or facility includes a separate unique health identifier for the department where items and services were furnished, in accordance with section 2799B–10 of such Act.”.

(B) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.) is amended by inserting after the item relating to section 725 the following new item:

“Sec. 726. Honest billing requirements applicable to plans and issuers.”.

(3) INTERNAL REVENUE CODE OF 1986.—

(A) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following:
"SEC. 9826. HONEST BILLING REQUIREMENTS APPLICABLE TO PLANS.

“A group health plan may not pay a claim for items and services furnished on or after January 1, 2026, to an individual at an off-campus outpatient department of a provider (as defined in section 2799B–10(b)) of the Public Health Service Act) submitted by a health care provider or facility unless such claim submitted by such provider or facility includes a separate unique health identifier for the department where items and services were furnished, in accordance with section 2799B–10 of such Act.”.

(B) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

“Sec. 9826. Honest billing requirements applicable to plans.”.

(b) REQUIRING A SEPARATE IDENTIFICATION NUMBER AND AN ATTESTATION FOR EACH OFF-CAMPUS OUTPATIENT DEPARTMENT OF A PROVIDER.—

(1) IN GENERAL.—Part E of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–131 et seq.) is amended by adding at the end the following:
"SEC. 2799B–10. HONEST BILLING REQUIREMENTS APPLICABLE TO PROVIDERS.

(a) Requirements Relating to Unique Health Identifiers.—For items and services furnished, on or after January 1, 2026, at an off-campus outpatient department of a provider to a participant, beneficiary, or enrollee with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a health care provider or facility may not submit a claim to the group health plan or health insurance issuer, bill the participant, beneficiary, or enrollee, or hold liable the participant, beneficiary, or enrollee, unless—

“(1) such provider or facility obtains a separate unique health identifier established for such department pursuant to section 1173(b) of the Social Security Act; and

“(2) such items and services are billed using the separate unique health identifier established for such department pursuant to paragraph (1).

(b) Off-campus Outpatient Department of a Provider.—The term ‘off-campus outpatient department of a provider’ means a department of a provider (as defined in section 413.65(a)(2) of title 42 of the Code of Federal Regulations, as in effect on the date of the enact-
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1. The Bipartisan Primary Care and Health Work-
   force Act) that is not located—

   “(1) on the campus (as defined in such section
   413.65(a)(2)) of such provider; or

   “(2) within the distance (described in such defi-
   nition of campus) from a remote location of a hos-
   pital (as defined in such section 413.65(a)(2)).

   “(c) Process for Reporting Suspected Viola-
   tions.—The Secretary shall establish a process under
   which a suspected violation of this section may be reported
   to such Secretary.

   “(d) Penalties.—The Secretary may assess a civil
   monetary penalty against a hospital for a violation under
   this section in an amount—

   “(1) in the case of a hospital with not more
   than 30 beds (as determined under section
   180.90(c)(2)(ii)(D) of title 45, Code of Federal Reg-
   ulations, as in effect on the date of the enactment
   of the Bipartisan Primary Care and Health Work-
   force Act (or any successor regulations), not to ex-
   ceed $300 per day that the violation is ongoing, as
   determined by the Secretary; and

   “(2) in the case of a hospital with more than
   30 beds (as so determined), not to exceed $5,500
per day that the violation is ongoing, as determined
by the Secretary.”.

(2) CONFORMING AMENDMENT.—Section
2799B–4(a)(1) of the Public Health Service Act (42
U.S.C. 300gg–134(a)(1)) is amended by inserting
“(other than section 2799B–10)” after “this part”.

SEC. 303. BANNING FACILITY FEES FOR CERTAIN SERV-
ICES.

Part E of title XXVII of the Public Health Service
Act (42 U.S.C. 300gg–131 et seq.), as amended by section
302(b), is further amended by adding at the end the fol-
lowing:

“SEC. 2799B–11. BANNING FACILITY FEES FOR CERTAIN
SERVICES.

“(a) IN GENERAL.—With respect to applicable items
and services furnished to an individual on or after January
1, 2026, a health care provider or facility may not charge
a facility fee (regardless of how the fee is labeled) to a
group health plan, a health insurance issuer offering
group or individual health insurance coverage, a partici-
pant, beneficiary, or enrollee in such a plan or coverage,
or an individual patient who is not covered by a group
health plan, health insurance coverage, or a Federal health
care program (as defined in section 1128(f) of the Social
Security Act).
“(b) **Applicable Items and Services.**—In this section, the term ‘applicable items and services’ means—

“(1) evaluation and management services described in section 1833(cc)(1)(B)(i) of the Social Security Act;

“(2) outpatient behavioral health services (not including partial hospitalizations, intensive outpatient program services, and other services not typically provided in an office setting (as the Secretary may determine)); and

“(3) any items and services (including the items and services described in paragraphs (1) and (2)) furnished via telehealth.”.

**SEC. 304. PREVENTION AND PUBLIC HEALTH FUND.**

Section 4002(b) of the Patient Protection and Affordable Care Act (42 U.S.C. 300u–11(b)) is amended by striking paragraphs (8) through (10) and inserting the following:

“(8) for each of fiscal years 2026 and 2027, $1,425,000,000;

“(9) for each of fiscal years 2028 and 2029, $1,495,000,000;

“(10) for fiscal year 2030, $1,680,000,000; and

“(11) for fiscal year 2031 and each fiscal year thereafter, $2,000,000,000.”.