I

108TH CONGRESS
2D SESSION

H. R. 5338

To reduce health care disparities and improve health care quality, to improve the collection of racial, ethnic, primary language, and socio-economic determination data for use by healthcare researchers and policymakers, to provide performance incentives for high performing hospitals and community health centers, and to expand current Federal programs seeking to eliminate health disparities.

IN THE HOUSE OF REPRESENTATIVES

OCTOBER 8, 2004

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

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A BILL

To reduce health care disparities and improve health care quality, to improve the collection of racial, ethnic, primary language, and socio-economic determination data for use by healthcare researchers and policymakers, to provide performance incentives for high performing hospitals and community health centers, and to expand current Federal programs seeking to eliminate health disparities.

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 ''Faircare Act''.

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

SEC. 2. FINDINGS.

(a) EVIDENCE OF HEALTHCARE DISPARITIES.—With respect to evidence of healthcare disparities, Congress makes the following findings:

(1) Healthcare disparities affect the lives, health, and livelihood of Americans, and increase the overall cost of health care in the United States.

(2) Minority patients with chronic diseases have been found less likely to receive the necessary services required to manage effectively these illnesses, such as routine blood pressure checks or eye examinations, and are less likely to receive treatments to cure these conditions, such as heart surgeries or kidney transplants.

(3) Studies have shown that non-English speaking patients report more satisfaction with health encounters and have better health outcomes after encounters with healthcare providers who speak their primary language.

(4) The Institute of Medicine's report ''In the Nation's Compelling Interest'', concluded that racial and ethnic minority healthcare providers are significantly more likely than their white peers to serve minority and medically underserved communities,

thereby helping to improve problems of limited minority access to care.

(5) Data from the National Center for Health Statistics demonstrates that minorities are less likely to receive routine cancer screenings even when they do have health insurance and access to healthcare providers, and once diagnosed with cancer, elderly minority patients are also less likely to receive appropriate treatment for pain associated with cancer.

(b) EVIDENCE OF INCONSISTENCIES IN HEALTHCARE QUALITY.—With respect to evidence of inconsistencies in healthcare quality, Congress makes the following findings:

(1) Inconsistent healthcare quality threatens the health of all Americans regardless of race, ethnicity, or socio-economic status.

(2) Studies by the RAND Corporation have shown that all patients in the United States have only a 55 percent possibility of receiving clinically appropriate care in the healthcare setting, despite the fact that the United States spends twice as much as other industrialized countries on health care.

(3) The control of hypertension is essential to reducing mortality from heart disease, stroke, and

diabetes complications, yet, only 23 percent of Americans with hypertension are adequately treated.

(4) About 1 in 5 elderly Americans are prescribed inappropriate medications.

(5) Only 21 percent of Americans with diabetes get all recommended checkups.

(6) One of the safest, simplest, and most cost-effective ways to reduce cancer morbidity and mortality is to increase screening rates for selected cancers including colorectal cancers, yet, less than half of men and women over the age of 50 report screening for colorectal cancers.

(7) In the United States, over ¼ of infants and toddlers of all races and ethnicities do not receive all recommended vaccines.

(8) Breakthroughs in treatments have enabled more patients to survive and live better, yet too many of these treatments are not being administered to all those who can benefit from them.

SEC. 3. DEFINITIONS.

In this Act:

(1) HEALTH DISPARITY POPULATIONS.—The term ''health disparity populations'' has the meaning given that term in section 485E(d) of the Public Health Service Act (42 U.S.C. 287c–31(d)).

(2) RACIAL AND ETHNIC MINORITY.—The term ''racial and ethnic minority'' has the meaning given the term ''racial and ethnic minority group'' in section 1707(g)(1) of the Public Health Service Act (42 U.S.C. 300u–6(g)(1)).

TITLE I—DEMOGRAPHIC DATA COLLECTION

SEC. 101. DATA ON RACE, ETHNICITY, HIGHEST EDUCATION LEVEL ATTAINED, AND PRIMARY LANGUAGE.

(a) PURPOSE.—It is the purpose of this section to promote data collection and reporting by race, ethnicity, highest education level attained, and primary language among federally supported health programs.

(b) AMENDMENT.—Part B of title II of the Public Health Service Act (42 U.S.C. 238 et seq.) is amended by adding at the end the following:

''SEC. 249. DATA ON RACE, ETHNICITY, HIGHEST EDUCATION LEVEL ATTAINED, AND PRIMARY LANGUAGE.

''(a) REQUIREMENTS.—

''(1) IN GENERAL.—Each health-related program operated by or that receives funding or reimbursement, in whole or in part, either directly or indirectly from the Department of Health and Human

Services shall, in accordance with the schedule described in subsection (e)—

"(A) require the collection, by the agency or program involved, of data on the race, ethnicity, highest education level attained, and primary language of each applicant for and recipient of health-related assistance under such program—

"(i) using, at a minimum, the categories for race and ethnicity described in the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity;

"(ii) using the standards developed under subsection (d) for the collection of language data;

"(iii) where practicable, collecting data for additional population groups if such groups can be aggregated into the minimum race and ethnicity categories as defined by the Office of Management and Budget; and

"(iv) where practicable, through self-reporting;

"(B) with respect to the collection of the data described in subparagraph (A) for applicants and recipients who are minors or otherwise legally incapacitated, require that—

"(i) such data be collected from the parent or legal guardian of such an applicant or recipient; and

"(ii) the preferred language of the parent or legal guardian of such an applicant or recipient be collected; and

"(C) ensure that the provision of assistance to an applicant or recipient of assistance is not denied or otherwise adversely affected because of the failure of the applicant or recipient to provide race, ethnicity, highest education level attained, and primary language data.

"(2) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to permit the use of information collected under this subsection in a manner that would adversely affect any individual providing any such information.

"(b) PROTECTION OF DATA.—The Secretary shall ensure (through the promulgation of regulations or otherwise) that all data collected pursuant to subsection (a) is protected—

''(1) under the same privacy protections as the Secretary applies to other health data under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033) relating to the privacy of individually identifiable health information and other protections; and

''(2) from all inappropriate internal use by any entity that collects, stores, or receives the data, including use of such data in determinations of eligibility (or continued eligibility) in health plans, and from other inappropriate uses, as defined by the Secretary.

''(c) COMPLIANCE WITH STANDARDS.—Data collected under subsection (a) shall be obtained, maintained, and presented (including for reporting purposes) in accordance with, at a minimum, the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity.

''(d) LANGUAGE COLLECTION STANDARDS.—Not later than 1 year after the date of enactment of this section, the Director of the Office of Minority Health, in consultation with the Office for Civil Rights of the Department of Health and Human Services, shall develop and

disseminate Standards for the Classification of Federal Data on Preferred Written and Spoken Language.

''(e) SCHEDULE OF COMPLIANCE.—Data collection under subsection (a) shall be required within the following time periods:

''(1) With respect to medicare-related data (under title XVIII of the Social Security Act), such data shall be collected not later than 2 years after the date of enactment of this section, including data related to—

''(A) the Medicare Hospital Quality Initiative;

''(B) the Center for Medicare and Medicaid Services Abstraction or Reporting Tools (referred to in this section as 'CART');

''(C) all CART equivalent private databases used to submit data for the Medicare Hospital Quality Initiative or medicare billing (including data for both medicare and non-medicare patients); and

''(D) all medicare billing communications.

''(2) With respect to data that is not currently mandated or collected and reported by the medicaid and State Children's Health Insurance Program (under titles XIX and XXI of the Social Security

Act), such data shall be collected not later than 4 years after the date of enactment of this section.

''(3) With respect to data relating to biomedical and health services research that is described in subsection (a), such data shall be collected not later than 6 years after the date of enactment of this section.

''(4) With respect to data relating to all other programs described in subsection (a), such data shall be collected not later than 6 years after the date of enactment of this section.

''(f) TECHNICAL ASSISTANCE FOR THE COLLECTION AND REPORTING OF DATA.—

''(1) IN GENERAL.—The Secretary may, either directly or through grant or contract, provide technical assistance to enable a healthcare program or an entity operating under such program to comply with the requirements of this section.

''(2) TYPES OF ASSISTANCE.—Assistance provided under this subsection may include assistance to—

''(A) enhance or upgrade information technology that will facilitate race, ethnicity, highest education level attained, and primary language data collection and analysis;

''(B) improve methods for health data collection and analysis including additional population groups beyond the Office of Management and Budget categories if such groups can be aggregated into the minimum race and ethnicity categories;

''(C) develop mechanisms for submitting collected data subject to existing privacy and confidentiality regulations; and

''(D) develop educational programs to inform health insurance issuers, health plans, health providers, health-related agencies, and the general public that data collection and reporting by race, ethnicity, and preferred language are legal and essential for eliminating health and healthcare disparities.

''(g) GRANTS FOR DATA COLLECTION BY COMMUNITY HEALTH CENTERS AND HOSPITALS.—

''(1) IN GENERAL.—The Secretary, in consultation with the Administrator of the Centers for Medicare & Medicaid Services and the Administrator of the Health Resources and Services Administration, is authorized to award grants for the conduct of 100 demonstration programs, 50 percent of which shall be conducted by community health centers and 50

percent of which shall be conducted by hospitals, to enhance the ability of such centers and hospitals to collect, analyze, and report the data required under subsection (a).

''(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1), a community health center or hospital shall—

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

''(B) provide assurances that the community health center or hospital will use, at a minimum, the racial and ethnic categories and the standards for collection described in the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity and available standards for language.

''(3) ACTIVITIES.—A grantee shall use amounts received under a grant under paragraph (1) to—

''(A) collect, analyze, and report data by race, ethnicity, highest education level attained, and primary language for patients served by the hospital (including emergency room patients

and patients served on an outpatient basis) or community health center;

"(B) enhance or upgrade computer technology that will facilitate racial, ethnic, highest education level attained, and primary language data collection and analysis;

"(C) provide analyses of disparities in health and healthcare, including specific disease conditions, diagnostic and therapeutic procedures, or outcomes;

"(D) improve health data collection and analysis for additional population groups beyond the Office of Management and Budget categories if such groups can be aggregated into the minimum race and ethnicity categories;

"(E) develop mechanisms for sharing collected data subject to privacy and confidentiality regulations;

"(F) develop educational programs to inform health insurance issuers, health plans, health providers, health-related agencies, patients, enrollees, and the general public that data collection, analysis, and reporting by race, ethnicity, and preferred language are legal and

tients, enrollees, and the general public that data collection, analysis, and reporting by race, ethnicity, and preferred language are legal and essential for eliminating disparities in health and healthcare; and

''(G) develop quality assurance systems designed to track disparities and quality improvement systems designed to eliminate disparities.

''(4) COMMUNITY HEALTH CENTER; HOSPITAL.—In this subsection:

''(A) COMMUNITY HEALTH CENTER.—The term 'community health center' means a federally qualified health center as defined in section 1861(aa)(4) of the Social Security Act.

''(B) HOSPITAL.—The term 'hospital' means a hospital participating in the prospective payment system under section 1886 of the Social Security Act and that is submitting quality indicators data in accordance with section 1886(b)(3)(B)(vii)(II) of the Social Security Act.

''(h) DEFINITION.—In this section, the term 'health-related program' means a program—

health services research, and other programs designated by the Secretary.

''(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $50,000,000 for fiscal year 2005, and such sums as may be necessary for each of fiscal years 2006 through 2015.''.

SEC. 102. REVISION OF HIPAA CLAIMS STANDARDS.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall revise the regulations promulgated under part C of title XI of the Social Security Act (42 U.S.C. 1320d et seq.), as added by the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191), relating to the collection of data on race, ethnicity, highest education level attained, and primary language in a health-related transaction to require—

(1) the use, at a minimum, of the categories for race and ethnicity described in the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity;

(2) the establishment of new data code sets for highest education level attained and primary language; and

(3) the designation of the racial, ethnic, highest education level attained, and primary language code sets as ''required'' for claims and enrollment data.

(b) DISSEMINATION.—The Secretary of Health and Human Services shall disseminate the new standards developed under subsection (a) to all health entities that are subject to the regulations described in such subsection and provide technical assistance with respect to the collection of the data involved.

(c) COMPLIANCE.—Not later than 1 year after the final promulgation of the regulations developed under subsection (a), the Secretary of Health and Human Services shall require that health entities comply with such standards.

(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2005 through 2015.

TITLE II—IMPROVED COLLECTION OF QUALITY DATA

SEC. 201. AUTHORITY OF AGENCY FOR HEALTHCARE RESEARCH AND QUALITY.

Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended—

(1) by redesignating part C as part D;

(2) by redesignating sections 921 through 928, as sections 931 through 938, respectively;

(3) in section 938(1) (as so redesignated), by striking ''921'' and inserting ''931''; and

(4) by inserting after part B the following:

''PART C—IMPROVED COLLECTION OF QUALITY DATA

''SEC. 921. GENERAL AUTHORITY OF THE AGENCY TO DETERMINE MEASURES.

''(a) IN GENERAL.—The Agency, in consultation with the Centers for Medicare & Medicaid Services, the Health Resources and Services Administration, the Office for Civil Rights of the Department of Health and Human Services, and the Office of Minority Health, shall have the authority to develop a new set of quality measures for each of the most common treatment settings. Such settings shall include, but not be limited to, hospitals, outpatient facilities, community health centers, long term care facilities, and other independent health care facilities.

''(b) REQUIREMENTS.—The quality measures developed under subsection (a) shall—

''(1) as closely as possible reflect the healthcare priority areas determined by the Institute of Medicine, the National Quality Forum, the Quality Initiative, and other healthcare quality and health care

disparity organizations as determined by the Secretary;

''(2) reflect the Institute of Medicine's goal of inclusiveness, improvability, and impact, addressing pervasive health and healthcare problems that produce a high level of morbidity and mortality, that disproportionally affect health disparity populations, and that have the potential for improvement with the consistent application of proven medical interventions; and

''(3) where practical, employ process measures of care.

''SEC. 922. USE OF HOSPITAL-SPECIFIC MEASURES.

''(a) DEVELOPMENT.—

''(1) IN GENERAL.—The Agency, in conjunction with the Centers for Medicare & Medicaid Services, shall develop a set of hospital quality measures.

''(2) USE.—The Secretary shall ensure that the Hospital Quality Initiative and the Robust Project Measures of the Centers for Medicare & Medicaid Services, and other Centers for Medicare & Medicaid Services directed quality initiatives use the hospital quality measures developed under paragraph (1).

''(b) SUBMISSION.—The information required under the measures developed under subsection (a) shall be sub-

mitted in accordance with section 1886(b)(3)(B)(vii) except that any reference to '2007' shall be deemed to be a reference to '2015'.

"SEC. 923. OUTPATIENT-SPECIFIC MEASURES.

''(a) IN GENERAL.—The Agency, in conjunction with the Bureau of Primary Health Care within the Health Resources and Services Administration, shall develop a set of outpatient quality measures. Such measures may be used as a supplement to existing demographic or quality reporting instruments or other quality reporting instruments utilized by the Health Resources and Services Administration.

''(b) VOLUNTARY SUBMISSION.—Submission of the supplementary information required under the measures developed under subsection (a) shall be voluntary.

''(c) DISCRETIONARY USE.—The measures developed under subsection (a) may be used as appropriate by the Hospital Quality Initiative and the Robust Project Measures and other Centers for Medicare & Medicaid Services-directed quality initiatives.

"SEC. 924. RANKING OF MEASURES.

''The Agency shall—

''(1) determine which of the quality measures developed under this part have the greatest potential to remedy healthcare disparities;

''(2) rank such quality measures according to such potential; and

''(3) rank such quality measures separately as applicable to hospitals and outpatients.

''SEC. 925. ADVISORY COMMITTEE ON QUALITY.

''(a) IN GENERAL.—The Agency shall establish an Advisory Committee on Quality (referred to in this section as the 'Advisory Committee') to recommend quality indicators for all quality data sets developed under this section. The Agency may designate a governmental or nongovernmental committee existing on the date of enactment of this part to serve as the Advisory Committee so long as the membership requirements of subsection (b) are complied with.

''(b) MEMBERSHIP.—The Advisory Committee shall be composed of not less than 10 members, including—

''(1) the Director;

''(2) the Administrator of the Centers for Medicare & Medicaid Services;

''(3) the Director of the Centers for Disease Control and Prevention;

''(4) the Administrator of the Health Resources and Services Administration;

''(5) the Director of the Office of Minority Health of the Department of Health and Human Services;

''(6) the Director of the Office for Civil Rights of the Department of Health and Human Services;

''(7) the Director of the Indian Health Service;

''(8) the chairperson of the Institute of Medicine National Roundtable on Healthcare Quality or other representatives of the Institute of Medicine;

''(9) the chairperson of the National Quality Forum;

''(10) the Director of the Joint Commission on Accreditation of Healthcare Organizations;

''(11) a representative of the Quality Initiative; and

''(12) other members to be appointed by the Secretary to represent other private, public, and non-profit stakeholders from medicine, healthcare, patient groups, and academia, who shall serve for a term of 3 years, and shall include a mix of different professions and broad geographic and culturally diverse representation.

''(c) DUTIES.—The Advisory Committee shall—

''(1) for each 3 year period beginning with fiscal year 2005, report to the Agency recommenda-

tions of quality indicators for all quality data sets described in this part;

''(2) in making the recommendations described in paragraph (1), focus on how best to integrate the findings of the Institute of Medicine, the National Quality Forum, the Quality Initiative, and other healthcare quality and healthcare disparity organizations as determined by the Secretary into quality measures that can be used in carrying out sections 922 and 923; and

''(3) address issues of continuity of care between ambulatory care and inpatient settings to the maximum extent practicable.

''SEC. 926. UPDATES OF CONDITIONS.

''(a) IN GENERAL.—At least once during every 3-year period beginning in fiscal year 2006, the Secretary shall direct the Agency to update the list of measures as described in sections 922 and 923. Such updates shall be based on recommendations of the Advisory Committee established under section 925 and determined in consultation with the Centers for Medicare & Medicaid Services and the Health Resources and Services Administration.

''(b) REQUIREMENT.—For each period in which an update is undertaken under subsection (a), the Agency shall ensure that the recommendations referred to such

subsection include measures for at least 4 additional conditions identified by the Institute of Medicine National Roundtable on Healthcare Quality, or measures developed by other healthcare disparity or healthcare quality organizations as determined by the Secretary, and not addressed by the quality reporting initiatives administered by the Secretary on the date of enactment of this part. The requirement of this section shall apply until there are measures for all Institute of Medicine priority areas.

"SEC. 927. REPORTING OF MEASURES.

''(a) IN GENERAL.—Not later than 5 years after the date of enactment of the Faircare Act, the Secretary shall enter into a contract with the Institute of Medicine to produce a report on the effectiveness of the quality measures developed by the Agency under this part in accurately assessing the quality of healthcare and healthcare disparities present in hospitals, community health centers, and other appropriate health care settings. Such report shall evaluate the progress made in improving the quality and consistency of healthcare and reducing healthcare disparities.

''(b) MANNER OF REPORTING.—All data reported under the Faircare Act (including data reported under this part) shall, to the maximum extent practicable, be re-

ported by race, ethnicity, primary language, and highest educational level attained in accordance with section 249.

''SEC. 928. EFFECTIVENESS RESEARCH GRANTS.

''The Office of Minority Health shall have the authority to award grants to study the effectiveness of all measures and programs established under this part. The Office shall recommend ways to improve such measure and programs and to implement the findings of the study conducted under section 927.

''SEC. 929. PROTECTION OF DATA.

''(a) RULE OF CONSTRUCTION.—Nothing in this part shall be construed to permit the use of information collected under this part in a manner that would adversely affect any individual providing any such information.

''(b) PROTECTION OF DATA.—The Secretary shall ensure (through the promulgation of regulations or otherwise) that all data collected pursuant to this part is protected—

''(1) under the same privacy protections as the Secretary applies to other health data under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033) relating to the privacy of individually identifiable health information and other protections; and

''(2) from all inappropriate internal use by any entity that collects, stores, or receives the data, including use of such data in determinations of eligibility (or continued eligibility) in health plans, and from other inappropriate uses, as defined by the Secretary.

''SEC. 929A. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated to carry out this section, $5,000,000 for each of fiscal years 2005 through 2007, and such sums as may be necessary for each of fiscal years 2008 through 2015.''.

SEC. 202. OFFICE OF NATIONAL HEALTHCARE DISPARITIES AND QUALITY.

Part A of title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended by adding at the end the following:

''SEC. 904. OFFICE OF NATIONAL HEALTHCARE DISPARITIES AND QUALITY.

''(a) IN GENERAL.—There is established within the Agency an Office of National Healthcare Disparities and Quality (referred to in this section as the 'Office'). Such Office shall administer the development and submission of the annual National Healthcare Disparities Report (under section 903(a)(6)) and the National Healthcare Quality

Report (under section 913(b)(2)) and carry out any other activities determined appropriate by the Secretary.

''(b) NATIONAL HEALTHCARE DISPARITIES AND QUALITY REPORTS.—

''(1) REPORTING REQUIREMENTS.—Not later than 1 year after the date of enactment of this section, and annually thereafter, the Office, in consultation with the Advisory Committee under section 925, the Office of Minority Health, and the Office for Civil Rights of the Department of Health and Human Services, shall submit to the Secretary, the appropriate committees of Congress, and the public—

''(A) a report on the disparities in healthcare which shall include data using the quality measures developed by the Agency under part C; and

''(B) a report on general healthcare quality.

''(2) LIMITATIONS.—The reports under paragraph (1) shall not identify individual hospitals or healthcare providers but shall include regional and State level data. To the maximum extent practicable, such reports shall—

''(A) indicate variations in healthcare quality between States and regions; and

''(B) to the maximum extent practicable, include data reported by race, ethnicity, primary language, and highest educational level attained in accordance with section 249.

''(3) AVAILABILITY.—The Office shall make such reports available to States, tribal organizations, and territorial governments upon request.

''(4) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, $10,000,000 for each of fiscal years 2005 through 2007, and such sums as may be necessary for each of fiscal years 2008 through 2015.

''(c) ACTIVITIES RELATING TO BEST PRACTICES.—

''(1) REPORT.—The Office of National Healthcare Disparities and Quality shall annually publish a report that describes the specific activities undertaken by Faircare Level I institutions, as designated under section 330P of this Act or section 1898(b) of the Social Security Act, that have resulted in a decrease in healthcare disparities or improved quality. Such reports shall include recommendations for carrying out such activities at other healthcare institutions.

''(2) CONFERENCE.—In conjunction with the publication of each report under paragraph (1), Office of National Healthcare Disparities and Quality shall hold an annual conference at which personnel from the Faircare institutions described in paragraph (1) can interact, advise, and consult with other healthcare institutions.

''(3) TECHNICAL ASSISTANCE.—The Office of National Healthcare Disparities and Quality shall offer technical assistance to healthcare institutions in reducing healthcare disparities, including through the dissemination of information through the Office Internet website, the development of an electronic mail list of best practices, the maintenance of a database and clearinghouse of best practices, and through other activities determined appropriate by the Office.

''(4) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, $5,000,000 for each of fiscal years 2005 to 2007, and such sums as may be necessary for each of fiscal years 2008 through 2015.''.

TITLE III—FAIRCARE HOSPITAL PROGRAM

SEC. 301. FAIRCARE HOSPITAL PROGRAM.

(a) PURPOSES.—The purposes of this section are to—

(1) require the Administrator of the Center for Medicare & Medicaid Services to—

(A) determine which hospitals have successfully reduced healthcare disparities between health disparity populations and other patients and improved healthcare quality based on the Hospital Quality Initiative measures established by the Agency for Healthcare Research and Quality under part C of title IX of the Public Health Service Act, as added by title II;

(B) verify the accuracy of the data submitted by such hospitals for purposes of being designated as a Faircare Hospital; and

(C) designate such hospitals as Faircare hospitals; and

(2) provide such hospitals with increased payments under the medicare program.

(b) PROGRAM.—Title XVIII of the Social Security Act, as amended by section 1016 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003

(Public Law 108–173; 117 Stat. 2447), is amended by adding at the end the following new section:

''PERFORMANCE INCENTIVE PAYMENT PROGRAM

''SEC. 1898. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary shall establish a program under which financial incentive payments are made in accordance with subsection (c) to subsection (d) hospitals (as defined in paragraph (2)) that have been designated under subsection (b).

''(2) SUBSECTION (d) HOSPITAL.—In this section, the term 'subsection (d) hospital' has the meaning given that term in section 1886(d)(1)(B).

''(b) DESIGNATION OF FAIRCARE HOSPITALS.—

''(1) IN GENERAL.—For each of fiscal years 2006 through 2014, the Secretary shall designate subsection (d) hospitals as follows:

''(A) LEVEL III FAIRCARE HOSPITAL.—The Secretary shall designate a subsection (d) hospital as a Level III Faircare hospital if the following requirements are met:

''(i) The subsection (d) hospital submitted data described in section 249 of the Public Health Service Act and part C of title IX of such Act to the Secretary in such form and manner and at such time specified by the Secretary under such sec-

tion and part and all such data submitted relating to patient quality includes data on the race, ethnicity, highest education level attained, and primary language of such patients.

''(ii) The Secretary determines that the subsection (d) hospital has improved the rate of delivery of high quality care during the 24-month period preceding such determination. A hospital shall be determined to meet the requirement in the preceding sentence if the Secretary determines that the hospital has increased the frequency of appropriate care for the majority of the applicable measures during such 24-month period by at least 5 percentage points within each such measure.

''(B) LEVEL II FAIRCARE HOSPITAL.—The Secretary shall designate a subsection (d) hospital as a Level II Faircare hospital if the following requirements are met:

''(i) The requirements described in clauses (i) and (ii) of subparagraph (A) are met.

"(ii) The Secretary determines that the subsection (d) hospital, during the 24-month period preceding such determination, has made a significant reduction in the disparities in the treatment of health disparity populations relative to other patients for—

"(I) the majority of the applicable measures; or

"(II) all of the 25 percent highest ranked applicable measures, as ranked for their importance for healthcare equity by the Agency for Healthcare Research and Quality under section 925 of the Public Health Service Act.

"(C) LEVEL I FAIRCARE HOSPITAL.—The Secretary shall designate a subsection (d) hospital as a Level I Faircare hospital if the following requirements are met:

"(i) The requirement described in subparagraph (A)(i) is met.

"(ii) Either—

"(I) the requirement described in subparagraph (A)(ii) is met; or

''(II) the Secretary determines that the frequency of appropriate care provided by the subsection (d) hospital for each applicable measure is at least 10 percentage points greater than the national average for the frequency of appropriate care for each applicable measure.

''(iii) The Secretary determines that the subsection (d) hospital, during the 24-month period preceding such determination, has had no significant disparity in the treatment of health disparity populations relative to other patients for all of the 75 percent highest ranked applicable measures, as ranked for their importance for healthcare equity by the Agency for Healthcare Research and Quality under section 925 of the Public Health Service Act.

''(2) APPLICABLE MEASURES DEFINED.—For purposes of this subsection, the term 'applicable measures' means the Hospital Quality Initiative measures established by the Agency for Healthcare

Research and Quality under part C of title IX of the Public Health Service Act.

''(3) HEALTH DISPARITY POPULATION DEFINED.—For purposes of this subsection, the term 'health disparity population' has the meaning given that term in section 485E(d) of the Public Health Service Act.

''(b) FINANCIAL INCENTIVE PAYMENTS.—

''(1) IN GENERAL.—Subject to paragraph (2) and subsection (d), for purposes of subclauses (XIX) and (XX) of section 1886(b)(3)(B)(i) for each of fiscal years 2007 through 2015, in the case of a subsection (d) hospital that has been designated under subsection (b) for a fiscal year, the Secretary shall increase the applicable percentage increase for the subsequent fiscal year for such hospital—

''(A) in the case of a Level I Faircare hospital, by 4 percentage points (or 8 percentage points in the case of such a hospital who is also described in subparagraph (B) of section 1923(b)(1)(B));

''(B) in the case of a Level II Faircare hospital, by 2 percentage points (or 4 percentage points in the case of such a hospital who

is also described in subparagraph (B) of section 1923(b)(1)(B)); and

"(C) in the case of a Level III Faircare hospital, by 1 percentage point (or 2 percentage points in the case of such a hospital who is also described in subparagraph (B) of section 1923(b)(1)(B)).

"(2) REDUCTION IN FINANCIAL INCENTIVE PAYMENTS IF INSUFFICIENT FUNDING AVAILABLE.—If the Secretary estimates that the total amount of increased payments under paragraph (1) for a fiscal year will exceed the funding available under subsection (d) for such increased payments for the fiscal year, the Secretary shall proportionately reduce the percentage points described in subparagraphs (A), (B), and (C) of paragraph (1) in order to eliminate such excess.

"(3) INCREASED PAYMENT NOT BUILT INTO THE BASE.—Any increased payment under paragraph (1) shall only apply to the fiscal year involved and the Secretary shall not take into account any such increased payment in computing the applicable percentage increase under clause (i)(XIX) for a subsequent fiscal year.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for making payments under subsection (b) such sums as may be necessary for each of fiscal years 2007 through 2015.''.

SEC. 302. TECHNICAL ASSISTANCE GRANTS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall provide technical assistance to eligible entities for the conduct of demonstration projects to improve the quality of healthcare and to reduce healthcare disparities.

(b) ELIGIBILITY.—To be eligible to receive technical assistance under subsection (a), an entity shall—

(1) be a hospital—

(A) that, by legal mandate or explicitly adopted mission, provides patients with access to services regardless of their ability to pay;

(B) that provides care or treatment for a substantial number of patients who are uninsured, are receiving assistance under a State program under title XIX of the Social Security Act, or are members of health disparity populations, as determined by the Secretary; and

(C)(i) with respect to which, not less than 50 percent of the entity's patient population is made up of racial and ethnic minorities; or

(ii) that serves a disproportionate percentage of local, minority racial and ethnic patients, or that has a patient population, at least 50 percent of which is limited English proficient; and

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

(c) TYPES OF ASSISTANCE.—The type of technical assistance that may be provided under this section shall be determined by the Centers for Medicare & Medicaid Services. Such assistance may include competitively awarded grants and other forms of assistance.

(d) USE OF ASSISTANCE.—Assistance provided under this section shall be used to improve healthcare quality or to reduce healthcare disparities.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2005 through 2015.

TITLE IV—COMMUNITY HEALTH CENTERS

SEC. 401. AUTHORITY OF BUREAU OF PRIMARY HEALTH CARE TO DEVELOP NEW REPORTING STANDARDS.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Bureau of Primary Health Care within the Health Resources and Services Administration, shall have the authority to—

(1) incorporate the outpatient measures of the Agency for Healthcare Research and Quality as developed under part C of title IX of the Public Health Service Act (as added by title II) into a supplement to existing demographic or quality reporting instruments or other quality reporting instruments utilized by the Health Resources and Services Administration;

(2) verify the submission of data under this title (and the amendments made by this title); and

(3) award Faircare designations in accordance with section 339P of the Public Health Service Act (as added by section 402).

(b) DISTRIBUTION.—Not later than 1 year after the date of enactment of this Act, the standards described in subsection (a) shall be designed and distributed to health

centers under section 339P of the Public Health Service Act (as added by section 402).

SEC. 402. FAIRCARE DESIGNATION FOR HEALTH CENTERS.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

"SEC. 399P. FAIRCARE DESIGNATION FOR HEALTH CENTERS.

"(a) DESIGNATION OF FAIRCARE HEALTH CENTERS.—

"(1) IN GENERAL.—For each of fiscal years 2006 through 2014, the Secretary shall designate health centers that receive Federal assistance as follows:

"(A) LEVEL III FAIRCARE HEALTH CENTER.—The Secretary shall designate a health center as a Level III Faircare health center if the following requirements are met:

"(i) The health center submitted data described in section 249 and part C of title IX to the Secretary in such form and manner and at such time specified by the Secretary under such section and part and all such data submitted relating to patient quality includes data on the race, ethnicity,

highest education level attained, and primary language of such patients.

''(ii) The Secretary determines that the health center has improved the rate of delivery of high quality care during the 24-month period preceding such determination. A health center shall be determined to meet the requirement in the preceding sentence if the Secretary determines that the health center has increased the frequency of appropriate care for the majority of the applicable measures during such 24-month period by at least 5 percentage points within each such measure.

''(B) LEVEL II FAIRCARE HEALTH CENTER.—The Secretary shall designate a health center as a Level II Faircare health center if the following requirements are met:

''(i) The requirements described in clauses (i) and (ii) of subparagraph (A) are met.

''(ii) The Secretary determines that the health center, during the 24-month period preceding such determination, has made a significant reduction in the dispari-

ties in the treatment of health disparity populations relative to other patients for—

"(I) the majority of the applicable measures; or

"(II) all of the 25 percent highest ranked applicable measures, as ranked for their importance for healthcare equity by the Agency for Healthcare Research and Quality under section 925.

"(C) LEVEL I FAIRCARE HEALTH CENTER.—The Secretary shall designate a health center as a Level I Faircare health center if the following requirements are met:

"(i) The requirement described subparagraph (A)(i) is met.

"(ii) Either—

"(I) the requirement described in subparagraph (A)(ii) is met; or

"(II) the Secretary determines that the frequency of appropriate care provided by the health center for each applicable measure is at least 10 percentage points greater than the national average for the frequency of ap-

propriate care for each applicable measure.

''(iii) The Secretary determines that the health center, during the 24-month period preceding such determination, has had no significant disparity in the treatment of health disparity populations relative to other patients for all of the 75 percent highest ranked applicable measures, as ranked for their importance for healthcare equity by the Agency for Healthcare Research and Quality under section 925.

''(2) APPLICABLE MEASURES DEFINED.—For purposes of this subsection, the term 'applicable measures' means the measures determined applicable under section 401(a) of the Faircare Act.

''(3) HEALTH DISPARITY POPULATION DEFINED.—For purposes of this subsection, the term 'health disparity population' has the meaning given that term in section 485E(d).

''(b) ELIGIBILITY FOR BONUSES.—A health center that is designated as a Faircare health center under subsection (a) shall be eligible for the following annual bonuses in the fiscal year following the year in which the health center is designated as a Faircare health center

under this section, with respect to assistance received under Federal health care programs:

''(1) With respect to a health center that is designated as a Level III Faircare health center, the Secretary shall determine the amount of such bonus which shall not be less than $200,000.

''(2) With respect to a health center that is designated as a Level II Faircare health center, the Secretary shall determine the amount of such bonus which shall not be less than $300,000.

''(3) With respect to a health center that is designated as a Level I Faircare health center, the Secretary shall determine the amount of such bonus which shall not be less than $500,000.

''(c) REDUCTION IN FINANCIAL INCENTIVE PAYMENTS IF INSUFFICIENT FUNDING AVAILABLE.—If the Secretary estimates that the total amount of bonuses under subsection (b) for a fiscal year will exceed the funding available under subsection (e) for such bonuses for the fiscal year, the Secretary shall proportionately reduce the amount of the bonus payments described in paragraphs (1), (2), and (3) of subsection (b) in order to eliminate such excess.

''(d) DEFINITION.—For purposes of this section, the term 'health center' means a Federally qualified health

center as defined in section 1861(aa)(4) of the Social Security Act.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2007 through 2015.''.

SEC. 403. GRANTS FOR TECHNICAL ASSISTANCE.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by section 402, is further amended by adding at the end the following:

''SEC. 399Q. GRANTS FOR TECHNICAL ASSISTANCE IN IMPROVING QUALITY.

''(a) IN GENERAL.—If a health center reporting data described in section 399P(a)(1)(A) for 3 or more years has demonstrated no improvement or a decrease in healthcare quality on at least 30 percent of all quality measures as designated under section 401(a) of the Faircare Act, such health center shall be given priority to receive technical assistance from the Bureau of Primary Health Care within the Health Resources and Services Administration.

''(b) TYPE OF ASSISTANCE.—The type of technical assistance that may be provided under subsection (a) shall be determined by the Bureau of Primary Health Care and

may include competitively awarded grants and other forms of assistance.

''(c) USE OF ASSISTANCE.—Assistance provided under this section shall be used by the health center to improve healthcare quality or reduce healthcare disparities.

''(d) DEFINITION.—For purposes of this section, the term 'health center' means a Federally qualified health center as defined in section 1861(aa)(4) of the Social Security Act.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, such sums as may be necessary for each of fiscal years 2007 through 2015.''.

SEC. 404. HEALTH DISPARITY COLLABORATIVES.

(a) IN GENERAL.—The Bureau of Primary Health Care within the Health Resources and Services Administration shall—

(1) provide technical assistance and funding to the Health Disparity Collaboratives; and

(2) expand the provision of technical assistance and funding, at the discretion of the Bureau, to priority areas designated by the Agency for Healthcare Research and Quality in consultation with the Advi-

sory Committee established under section 925 of the Public Health Service Act.

(b) FUNDING.—The Bureau of Primary Health Care within the Health Resources and Services Administration shall continue to fund collaboratives with a goal of adding at least 50 new health centers each year.

(c) DEFINITION.—For purposes of this section, the term 'health center' means a Federally qualified health center as defined in section 1861(aa)(4) of the Social Security Act.

(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2005 through 2015.

TITLE V—REACH 2010

SEC. 501. EXPANSION OF REACH 2010.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention, shall award grants and carry out other activities to expand the Racial and Ethnic Approaches to Community Health Program (REACH 2010) program to support coalitions in all 50 States and territories.

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

(1) be a coalition that is comprised of, at a minimum, a community-based organization and at least 3 other organizations, one of which is either a State or local health department or a university or research organization; and

(2) prepare and submit to the Secretary of Health and Human Services an application at such time, in such manner, and containing such information as the Secretary may require.

(c) USE OF GRANTS.—Amounts provided under a grant under this section shall be used to support community coalitions in designing, implementing, and evaluating community-driven strategies to eliminate health disparities, with an emphasis on African Americans, American Indians, Alaska Natives, Asian Americans, Hispanic Americans, and Pacific Islanders.

(d) PRIORITY AREAS.—In carrying out the Racial and Ethnic Approaches to Community Health Program (REACH 2010) program, the Director of the Centers for Disease Control and Prevention shall include the following priority areas:

(1) Cardiovascular disease.

(2) Immunizations.

(3) Breast and cervical cancer screening and management.

(4) Diabetes.

(5) HIV/AIDS.

(6) Infant mortality.

(7) Asthma.

(8) Obesity.

(8) At the discretion of the Director of the Centers for Disease Control and Prevention, any additional priority areas determined appropriate by the Agency for Healthcare Research and Quality in consultation with the Advisory Committee established under section 925 of the Public Health Service Act.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section and the Racial and Ethnic Approaches to Community Health Program (REACH 2010) program, $200,000,000 for each of fiscal years 2005 to 2007, and such sums as may be necessary for each of fiscal years 2008 through 2015.

TITLE VI—MALPRACTICE INSURANCE RELIEF

SEC. 601. REFUNDABLE TAX CREDIT FOR THE COST OF MALPRACTICE INSURANCE FOR CERTAIN PROVIDERS.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by redes-

ignating section 36 as section 37 and by inserting after section 35 the following new section:

"SEC. 36. CERTAIN MALPRACTICE INSURANCE COSTS.

"(a) IN GENERAL.—In the case of an eligible health care provider, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to the applicable percentage of qualified malpractice insurance expenditures paid or incurred during the taxable year.

"(b) APPLICABLE PERCENTAGE.—For purposes of this section—

"(1) IN GENERAL.—The applicable percentage shall be—

"(A) 10 percent for any taxable year for which the person claiming the credit is an eligible health care provider, plus

"(B) 5 percent for each consecutive prior taxable year ending after the date of enactment of this section for which such person was an eligible health care provider.

"(2) LIMITATION.—The applicable percentage shall not exceed 25 percent.

"(c) ELIGIBLE HEALTH CARE PROVIDER.—For purposes of this section, the term 'eligible health care provider' means—

''(1) a public or private nonprofit hospital which is—

''(A) located in a medically underserved area (as defined in section 1302(7) of the Public Health Service Act) or in a health professional shortage area (as designated under section 332 of the Public Health Service Act), and

''(B) designated as a Level I Faircare Hospital under section 339P of the Public Health Service Act or section 1898 of the Social Security Act for the year in which such hospital's taxable year ends, and

''(2) a physician for whom not less than 66 percent of the practice for the taxable year is at a facility described in paragraph (1).

''(d) QUALIFIED MEDICAL MALPRACTICE INSURANCE EXPENDITURE.—The term 'qualified medical malpractice insurance expenditure' means so much of any professional insurance premium, surcharge, payment or other cost or expense required as a condition of State licensure which is incurred by an eligible health care provider in a taxable year for the sole purpose of providing or furnishing general medical malpractice liability insurance for such eligible health care provider.''.

(b) DENIAL OF DOUBLE BENEFIT.—Section 280C of the Internal Revenue Code of 1986 (relating to certain expenses for which credits are allowable) is amended by adding at the end the following new subsection:

''(d) CREDIT FOR MEDICAL MALPRACTICE LIABILITY INSURANCE PREMIUMS.—

''(1) IN GENERAL.—No deduction shall be allowed for that portion of the qualified medical malpractice insurance expenditures otherwise allowable as a deduction for the taxable year which is equal to the amount of the credit allowable for the taxable year under section 36.

''(2) CONTROLLED GROUPS.—In the case of a corporation which is a member of a controlled group of corporations (within the meaning of section 41(f)(5)) or a trade or business which is treated as being under common control with other trades or business (within the meaning of section 41(f)(1)(B)), this subsection shall be applied under rules prescribed by the Secretary similar to the rules applicable under subparagraphs (A) and (B) of section 41(f)(1).''.

(c) CONFORMING AMENDMENT.—Paragraph (2) of section 1324(b) of title 31, United States Code, is amend-

ed by inserting before the period ''or from section 36 of such Code''.

(d) CLERICAL AMENDMENT.—The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by striking the item related to section 36 and inserting the following new items:

''Sec. 36. Certain malpractice insurance costs.
''Sec. 37. Overpayments of tax.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to expenditures incurred after December 31, 2005.

(f) AVAILABILITY OF CREDIT FOR TAX EXEMPT ORGANIZATIONS.—The Secretary of the Treasury shall administer the credit allowable under section 36 of the Internal Revenue Code of 1986 (as added by this section) in such a manner so as to minimize to the largest extent possible the administrative burden on tax exempt organizations claiming the credit.

SEC. 602. GRANTS TO NON-PROFIT HOSPITALS.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration, shall award grants to eligible entities to assist such entities in defraying qualified medical malpractice insurance expenditures.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

(1) be a Faircare Level I non-profit hospital (as determined under section 1898(b) of the Social Security Act) in the preceding fiscal year;

(2) not be eligible to claim the tax credit under section 36 of the Internal Revenue Code of 1986;

(3) prepare and submit to the Secretary of Health and Human Services an application at such time, in such manner, and containing such information as the Secretary may require.

(c) AMOUNT OF GRANT.—The amount of a grant awarded to an eligible entity under this section shall be—

(1) with respect to the first year of the grant, an amount equal to 10 percent of the qualified medical malpractice insurance expenditures of the entity for the year;

(2) with respect to the second year of the grant, an amount equal to 15 percent of the qualified medical malpractice insurance expenditures of the entity for the year;

(3) with respect to the third year of the grant, an amount equal to 20 percent of the qualified medical malpractice insurance expenditures of the entity for the year; and

(4) with respect to the fourth and subsequent years of the grant, an amount equal to 25 percent of the qualified medical malpractice insurance expenditures of the entity for the year.

(d) DEFINITION.—In this section, the term ''qualified medical malpractice insurance expenditure'' has the meaning given such term in section 36(d) of the Internal Revenue Code of 1986.

SEC. 603. GRANTS FOR RESEARCH INTO QUALITY OF CARE AND MEDICAL ERRORS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall award grants to eligible entities to study the relationship between institutions that are designated as Faircare hospitals under section 1898(b) of the Social Security Act and medical errors or the rate of claims of malpractice.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall prepare and submit to the Secretary of Health and Human Services an application at such time, in such manner, and containing such information as the Secretary may require.

SEC. 604. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated to carry out this title, such sums as may be necessary for each of fiscal years 2005 through 2015.

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