

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.

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## 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.

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

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

2 (a) SHORT TITLE.—This Act may be cited as the  
3 “Faircare Act”.

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

Sec. 1. Short title; table of contents.

Sec. 2. Findings.

Sec. 3. Definitions.

TITLE I—DEMOGRAPHIC DATA COLLECTION

Sec. 101. Data on race, ethnicity, highest education level attained, and primary language.

Sec. 102. Revision of HIPAA claims standards.

TITLE II—IMPROVED COLLECTION OF QUALITY DATA

Sec. 201. Authority of Agency for Healthcare Research and Quality.

“PART C—IMPROVED COLLECTION OF QUALITY DATA

“Sec. 921. General authority of the Agency to determine measures.

“Sec. 922. Use of hospital-specific measures.

“Sec. 923. Outpatient-specific measures.

“Sec. 924. Ranking of measures.

“Sec. 925. Advisory Committee on Quality.

“Sec. 926. Updates of conditions.

“Sec. 927. Reporting of measures.

“Sec. 928. Voluntary submission of data.

“Sec. 929. Authorization of appropriations.

Sec. 202. Office of national healthcare disparities and quality.

TITLE III—FAIRCARE HOSPITAL PROGRAM

Sec. 301. Faircare hospital program.

Sec. 302. Technical assistance grants.

TITLE IV—COMMUNITY HEALTH CENTERS.

Sec. 401. Authority of Bureau of Primary Health Care to develop new reporting standards.

Sec. 402. Faircare designation for health centers.

Sec. 403. Grants for technical assistance.

Sec. 404. Health disparity collaboratives.

TITLE V—REACH 2010

Sec. 501. Expansion of REACH 2010

TITLE VI—MALPRACTICE INSURANCE RELIEF

Sec. 601. Refundable tax credit for the cost of malpractice insurance for certain providers.

Sec. 602. Grants to non-profit hospitals.

Sec. 603. Grants for research into quality of care and medical errors.

Sec. 604. Authorization of appropriations.

1 **SEC. 2. FINDINGS.**

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

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

8 (2) Minority patients with chronic diseases have  
9 been found less likely to receive the necessary serv-  
10 ices required to manage effectively these illnesses,  
11 such as routine blood pressure checks or eye exami-  
12 nations, and are less likely to receive treatments to  
13 cure these conditions, such as heart surgeries or kid-  
14 ney transplants.

15 (3) Studies have shown that non-English speak-  
16 ing patients report more satisfaction with health en-  
17 counters and have better health outcomes after en-  
18 counters with healthcare providers who speak their  
19 primary language.

20 (4) The Institute of Medicine’s report “In the  
21 Nation’s Compelling Interest”, concluded that racial  
22 and ethnic minority healthcare providers are signifi-  
23 cantly more likely than their white peers to serve mi-  
24 nority and medically underserved communities,

1       thereby helping to improve problems of limited mi-  
2       nority access to care.

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

10       (b)     EVIDENCE     OF     INCONSISTENCIES     IN  
11   HEALTHCARE QUALITY.—With respect to evidence of in-  
12   consistencies in healthcare quality, Congress makes the  
13   following findings:

14           (1) Inconsistent healthcare quality threatens  
15       the health of all Americans regardless of race, eth-  
16       nicity, or socio-economic status.

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

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

1 diabetes complications, yet, only 23 percent of Amer-  
2 icans with hypertension are adequately treated.

3 (4) About 1 in 5 elderly Americans are pre-  
4 scribed inappropriate medications.

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

7 (6) One of the safest, simplest, and most cost-  
8 effective ways to reduce cancer morbidity and mor-  
9 tality is to increase screening rates for selected can-  
10 cers including colorectal cancers, yet, less than half  
11 of men and women over the age of 50 report screen-  
12 ing for colorectal cancers.

13 (7) In the United States, over  $\frac{1}{4}$  of infants and  
14 toddlers of all races and ethnicities do not receive all  
15 recommended vaccines.

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

20 **SEC. 3. DEFINITIONS.**

21 In this Act:

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

1           (2) RACIAL AND ETHNIC MINORITY.—The term  
 2           “racial and ethnic minority” has the meaning given  
 3           the term “racial and ethnic minority group” in sec-  
 4           tion 1707(g)(1) of the Public Health Service Act (42  
 5           U.S.C. 300u–6(g)(1)).

## 6       **TITLE I—DEMOGRAPHIC DATA** 7                               **COLLECTION**

### 8       **SEC. 101. DATA ON RACE, ETHNICITY, HIGHEST EDUCATION** 9                               **LEVEL ATTAINED, AND PRIMARY LANGUAGE.**

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

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

### 17       **“SEC. 249. DATA ON RACE, ETHNICITY, HIGHEST EDU-** 18                               **CATION LEVEL ATTAINED, AND PRIMARY** 19                               **LANGUAGE.**

20       “(a) REQUIREMENTS.—

21               “(1) IN GENERAL.—Each health-related pro-  
 22       gram operated by or that receives funding or reim-  
 23       bursement, in whole or in part, either directly or in-  
 24       directly from the Department of Health and Human

1 Services shall, in accordance with the schedule de-  
2 scribed in subsection (e)—

3 “(A) require the collection, by the agency  
4 or program involved, of data on the race, eth-  
5 nicity, highest education level attained, and pri-  
6 mary language of each applicant for and recipi-  
7 ent of health-related assistance under such pro-  
8 gram—

9 “(i) using, at a minimum, the cat-  
10 egories for race and ethnicity described in  
11 the 1997 Office of Management and Budg-  
12 et Standards for Maintaining, Collecting,  
13 and Presenting Federal Data on Race and  
14 Ethnicity;

15 “(ii) using the standards developed  
16 under subsection (d) for the collection of  
17 language data;

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

24 “(iv) where practicable, through self-  
25 reporting;

1           “(B) with respect to the collection of the  
2           data described in subparagraph (A) for appli-  
3           cants and recipients who are minors or other-  
4           wise legally incapacitated, require that—

5                   “(i) such data be collected from the  
6                   parent or legal guardian of such an appli-  
7                   cant or recipient; and

8                   “(ii) the preferred language of the  
9                   parent or legal guardian of such an appli-  
10                  cant or recipient be collected; and

11               “(C) ensure that the provision of assist-  
12               ance to an applicant or recipient of assistance  
13               is not denied or otherwise adversely affected be-  
14               cause of the failure of the applicant or recipient  
15               to provide race, ethnicity, highest education  
16               level attained, and primary language data.

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

22               “(b) PROTECTION OF DATA.—The Secretary shall  
23               ensure (through the promulgation of regulations or other-  
24               wise) that all data collected pursuant to subsection (a) is  
25               protected—



1           “(1) under the same privacy protections as the  
2       Secretary applies to other health data under the reg-  
3       ulations promulgated under section 264(c) of the  
4       Health Insurance Portability and Accountability Act  
5       of 1996 (Public Law 104–191; 110 Stat. 2033) re-  
6       lating to the privacy of individually identifiable  
7       health information and other protections; and

8           “(2) from all inappropriate internal use by any  
9       entity that collects, stores, or receives the data, in-  
10      cluding use of such data in determinations of eligi-  
11      bility (or continued eligibility) in health plans, and  
12      from other inappropriate uses, as defined by the  
13      Secretary.

14      “(c) COMPLIANCE WITH STANDARDS.—Data col-  
15      lected under subsection (a) shall be obtained, maintained,  
16      and presented (including for reporting purposes) in ac-  
17      cordance with, at a minimum, the 1997 Office of Manage-  
18      ment and Budget Standards for Maintaining, Collecting,  
19      and Presenting Federal Data on Race and Ethnicity.

20      “(d) LANGUAGE COLLECTION STANDARDS.—Not  
21      later than 1 year after the date of enactment of this sec-  
22      tion, the Director of the Office of Minority Health, in con-  
23      sultation with the Office for Civil Rights of the Depart-  
24      ment of Health and Human Services, shall develop and

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

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

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

11 “(A) the Medicare Hospital Quality Initia-  
12 tive;

13 “(B) the Center for Medicare and Med-  
14 icaid Services Abstraction or Reporting Tools  
15 (referred to in this section as ‘CART’);

16 “(C) all CART equivalent private data-  
17 bases used to submit data for the Medicare  
18 Hospital Quality Initiative or medicare billing  
19 (including data for both medicare and non-  
20 medicare patients); and

21 “(D) all medicare billing communications.

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

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

3 “(3) With respect to data relating to biomedical  
4 and health services research that is described in sub-  
5 section (a), such data shall be collected not later  
6 than 6 years after the date of enactment of this sec-  
7 tion.

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

12 “(f) TECHNICAL ASSISTANCE FOR THE COLLECTION  
13 AND REPORTING OF DATA.—

14 “(1) IN GENERAL.—The Secretary may, either  
15 directly or through grant or contract, provide tech-  
16 nical assistance to enable a healthcare program or  
17 an entity operating under such program to comply  
18 with the requirements of this section.

19 “(2) TYPES OF ASSISTANCE.—Assistance pro-  
20 vided under this subsection may include assistance  
21 to—

22 “(A) enhance or upgrade information tech-  
23 nology that will facilitate race, ethnicity, highest  
24 education level attained, and primary language  
25 data collection and analysis;

1           “(B) improve methods for health data col-  
2           lection and analysis including additional popu-  
3           lation groups beyond the Office of Management  
4           and Budget categories if such groups can be  
5           aggregated into the minimum race and ethnicity  
6           categories;

7           “(C) develop mechanisms for submitting  
8           collected data subject to existing privacy and  
9           confidentiality regulations; and

10          “(D) develop educational programs to in-  
11          form health insurance issuers, health plans,  
12          health providers, health-related agencies, and  
13          the general public that data collection and re-  
14          porting by race, ethnicity, and preferred lan-  
15          guage are legal and essential for eliminating  
16          health and healthcare disparities.

17          “(g) GRANTS FOR DATA COLLECTION BY COMMU-  
18          NITY HEALTH CENTERS AND HOSPITALS.—

19          “(1) IN GENERAL.—The Secretary, in consulta-  
20          tion with the Administrator of the Centers for Medi-  
21          care & Medicaid Services and the Administrator of  
22          the Health Resources and Services Administration,  
23          is authorized to award grants for the conduct of 100  
24          demonstration programs, 50 percent of which shall  
25          be conducted by community health centers and 50

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

5 “(2) ELIGIBILITY.—To be eligible to receive a  
6 grant under paragraph (1), a community health cen-  
7 ter or hospital shall—

8 “(A) prepare and submit to the Secretary  
9 an application at such time, in such manner,  
10 and containing such information as the Sec-  
11 retary may require; and

12 “(B) provide assurances that the commu-  
13 nity health center or hospital will use, at a min-  
14 imum, the racial and ethnic categories and the  
15 standards for collection described in the 1997  
16 Office of Management and Budget Standards  
17 for Maintaining, Collecting, and Presenting  
18 Federal Data on Race and Ethnicity and avail-  
19 able standards for language.

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

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

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

3 “(B) enhance or upgrade computer tech-  
4 nology that will facilitate racial, ethnic, highest  
5 education level attained, and primary language  
6 data collection and analysis;

7 “(C) provide analyses of disparities in  
8 health and healthcare, including specific disease  
9 conditions, diagnostic and therapeutic proce-  
10 dures, or outcomes;

11 “(D) improve health data collection and  
12 analysis for additional population groups be-  
13 yond the Office of Management and Budget  
14 categories if such groups can be aggregated into  
15 the minimum race and ethnicity categories;

16 “(E) develop mechanisms for sharing col-  
17 lected data subject to privacy and confiden-  
18 tiality regulations;

19 “(F) develop educational programs to in-  
20 form health insurance issuers, health plans,  
21 health providers, health-related agencies, pa-  
22 tients, enrollees, and the general public that  
23 data collection, analysis, and reporting by race,  
24 ethnicity, and preferred language are legal and

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

6           “(G) develop quality assurance systems de-  
7           signed to track disparities and quality improve-  
8           ment systems designed to eliminate disparities.

9           “(4) COMMUNITY HEALTH CENTER; HOS-  
10          PITAL.—In this subsection:

11           “(A) COMMUNITY HEALTH CENTER.—The  
12           term ‘community health center’ means a feder-  
13           ally qualified health center as defined in section  
14           1861(aa)(4) of the Social Security Act.

15           “(B) HOSPITAL.—The term ‘hospital’  
16           means a hospital participating in the prospec-  
17           tive payment system under section 1886 of the  
18           Social Security Act and that is submitting qual-  
19           ity indicators data in accordance with section  
20           1886(b)(3)(B)(vii)(II) of the Social Security  
21           Act.

22           “(h) DEFINITION.—In this section, the term ‘health-  
23          related program’ means a program—

1 health services research, and other programs des-  
2 ignated by the Secretary.

3 “(i) AUTHORIZATION OF APPROPRIATIONS.—There is  
4 authorized to be appropriated to carry out this section,  
5 \$50,000,000 for fiscal year 2005, and such sums as may  
6 be necessary for each of fiscal years 2006 through 2015.”.

7 **SEC. 102. REVISION OF HIPAA CLAIMS STANDARDS.**

8 (a) IN GENERAL.—Not later than 1 year after the  
9 date of enactment of this Act, the Secretary of Health and  
10 Human Services shall revise the regulations promulgated  
11 under part C of title XI of the Social Security Act (42  
12 U.S.C. 1320d et seq.), as added by the Health Insurance  
13 Portability and Accountability Act of 1996 (Public Law  
14 104–191), relating to the collection of data on race, eth-  
15 nicity, highest education level attained, and primary lan-  
16 guage in a health-related transaction to require—

17 (1) the use, at a minimum, of the categories for  
18 race and ethnicity described in the 1997 Office of  
19 Management and Budget Standards for Maintain-  
20 ing, Collecting, and Presenting Federal Data on  
21 Race and Ethnicity;

22 (2) the establishment of new data code sets for  
23 highest education level attained and primary lan-  
24 guage; and



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

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

10 (c) COMPLIANCE.—Not later than 1 year after the  
 11 final promulgation of the regulations developed under sub-  
 12 section (a), the Secretary of Health and Human Services  
 13 shall require that health entities comply with such stand-  
 14 ards.

15 (d) AUTHORIZATION OF APPROPRIATIONS.—There is  
 16 authorized to be appropriated to carry out this section,  
 17 such sums as may be necessary for each of fiscal years  
 18 2005 through 2015.

19 **TITLE II—IMPROVED**  
 20 **COLLECTION OF QUALITY DATA**  
 21 **SEC. 201. AUTHORITY OF AGENCY FOR HEALTHCARE RE-**  
 22 **SEARCH AND QUALITY.**

23 Title IX of the Public Health Service Act (42 U.S.C.  
 24 299 et seq.) is amended—

25 (1) by redesignating part C as part D;

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

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

5 (4) by inserting after part B the following:

6 **“PART C—IMPROVED COLLECTION OF QUALITY**  
7 **DATA**

8 **“SEC. 921. GENERAL AUTHORITY OF THE AGENCY TO DE-**  
9 **TERMINE MEASURES.**

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

20 “(b) REQUIREMENTS.—The quality measures devel-  
21 oped under subsection (a) shall—

22 “(1) as closely as possible reflect the healthcare  
23 priority areas determined by the Institute of Medi-  
24 cine, the National Quality Forum, the Quality Initia-  
25 tive, and other healthcare quality and health care

1       disparity organizations as determined by the Sec-  
2       retary;

3           “(2) reflect the Institute of Medicine’s goal of  
4       inclusiveness, improvability, and impact, addressing  
5       pervasive health and healthcare problems that  
6       produce a high level of morbidity and mortality, that  
7       disproportionally affect health disparity populations,  
8       and that have the potential for improvement with  
9       the consistent application of proven medical inter-  
10      ventions; and

11           “(3) where practical, employ process measures  
12      of care.

13   **“SEC. 922. USE OF HOSPITAL-SPECIFIC MEASURES.**

14       “(a) DEVELOPMENT.—

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

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

24       “(b) SUBMISSION.—The information required under  
25       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;

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

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

5   **“SEC. 925. ADVISORY COMMITTEE ON QUALITY.**

6       “(a) IN GENERAL.—The Agency shall establish an  
7   Advisory Committee on Quality (referred to in this section  
8   as the ‘Advisory Committee’) to recommend quality indica-  
9   tors for all quality data sets developed under this section.  
10   The Agency may designate a governmental or nongovern-  
11   mental committee existing on the date of enactment of this  
12   part to serve as the Advisory Committee so long as the  
13   membership requirements of subsection (b) are complied  
14   with.

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

17           “(1) the Director;

18           “(2) the Administrator of the Centers for Medi-  
19       care & Medicaid Services;

20           “(3) the Director of the Centers for Disease  
21       Control and Prevention;

22           “(4) the Administrator of the Health Resources  
23       and Services Administration;

1           “(5) the Director of the Office of Minority  
2       Health of the Department of Health and Human  
3       Services;

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

6           “(7) the Director of the Indian Health Service;

7           “(8) the chairperson of the Institute of Medi-  
8       cine National Roundtable on Healthcare Quality or  
9       other representatives of the Institute of Medicine;

10          “(9) the chairperson of the National Quality  
11       Forum;

12          “(10) the Director of the Joint Commission on  
13       Accreditation of Healthcare Organizations;

14          “(11) a representative of the Quality Initiative;  
15       and

16          “(12) other members to be appointed by the  
17       Secretary to represent other private, public, and  
18       non-profit stakeholders from medicine, healthcare,  
19       patient groups, and academia, who shall serve for a  
20       term of 3 years, and shall include a mix of different  
21       professions and broad geographic and culturally di-  
22       verse representation.

23       “(c) DUTIES.—The Advisory Committee shall—

24           “(1) for each 3 year period beginning with fis-  
25       cal year 2005, report to the Agency recommenda-

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

3            “(2) in making the recommendations described  
4        in paragraph (1), focus on how best to integrate the  
5        findings of the Institute of Medicine, the National  
6        Quality Forum, the Quality Initiative, and other  
7        healthcare quality and healthcare disparity organiza-  
8        tions as determined by the Secretary into quality  
9        measures that can be used in carrying out sections  
10       922 and 923; and

11           “(3) address issues of continuity of care be-  
12        tween ambulatory care and inpatient settings to the  
13        maximum extent practicable.

14    **“SEC. 926. UPDATES OF CONDITIONS.**

15        “(a) IN GENERAL.—At least once during every 3-year  
16        period beginning in fiscal year 2006, the Secretary shall  
17        direct the Agency to update the list of measures as de-  
18        scribed in sections 922 and 923. Such updates shall be  
19        based on recommendations of the Advisory Committee es-  
20        tablished under section 925 and determined in consulta-  
21        tion with the Centers for Medicare & Medicaid Services  
22        and the Health Resources and Services Administration.

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

1 subsection include measures for at least 4 additional con-  
2 ditions identified by the Institute of Medicine National  
3 Roundtable on Healthcare Quality, or measures developed  
4 by other healthcare disparity or healthcare quality organi-  
5 zations as determined by the Secretary, and not addressed  
6 by the quality reporting initiatives administered by the  
7 Secretary on the date of enactment of this part. The re-  
8 quirement of this section shall apply until there are meas-  
9 ures for all Institute of Medicine priority areas.

10 **“SEC. 927. REPORTING OF MEASURES.**

11       “(a) IN GENERAL.—Not later than 5 years after the  
12 date of enactment of the Faircare Act, the Secretary shall  
13 enter into a contract with the Institute of Medicine to  
14 produce a report on the effectiveness of the quality meas-  
15 ures developed by the Agency under this part in accurately  
16 assessing the quality of healthcare and healthcare dispari-  
17 ties present in hospitals, community health centers, and  
18 other appropriate health care settings. Such report shall  
19 evaluate the progress made in improving the quality and  
20 consistency of healthcare and reducing healthcare dispari-  
21 ties.

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



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

3 **“SEC. 928. EFFECTIVENESS RESEARCH GRANTS.**

4 “The Office of Minority Health shall have the author-  
5 ity to award grants to study the effectiveness of all meas-  
6 ures and programs established under this part. The Office  
7 shall recommend ways to improve such measure and pro-  
8 grams and to implement the findings of the study con-  
9 ducted under section 927.

10 **“SEC. 929. PROTECTION OF DATA.**

11 “(a) RULE OF CONSTRUCTION.—Nothing in this part  
12 shall be construed to permit the use of information col-  
13 lected under this part in a manner that would adversely  
14 affect any individual providing any such information.

15 “(b) PROTECTION OF DATA.—The Secretary shall  
16 ensure (through the promulgation of regulations or other-  
17 wise) that all data collected pursuant to this part is pro-  
18 tected—

19 “(1) under the same privacy protections as the  
20 Secretary applies to other health data under the reg-  
21 ulations promulgated under section 264(c) of the  
22 Health Insurance Portability and Accountability Act  
23 of 1996 (Public Law 104–191; 110 Stat. 2033) re-  
24 lating to the privacy of individually identifiable  
25 health information and other protections; and

1           “(2) from all inappropriate internal use by any  
 2           entity that collects, stores, or receives the data, in-  
 3           cluding use of such data in determinations of eligi-  
 4           bility (or continued eligibility) in health plans, and  
 5           from other inappropriate uses, as defined by the  
 6           Secretary.

7   **“SEC. 929A. AUTHORIZATION OF APPROPRIATIONS.**

8           “‘There is authorized to be appropriated to carry out  
 9           this section, \$5,000,000 for each of fiscal years 2005  
 10          through 2007, and such sums as may be necessary for  
 11          each of fiscal years 2008 through 2015.’”.

12   **SEC. 202. OFFICE OF NATIONAL HEALTHCARE DISPARITIES**  
 13                           **AND QUALITY.**

14          Part A of title IX of the Public Health Service Act  
 15          (42 U.S.C. 299 et seq.) is amended by adding at the end  
 16          the following:

17   **“SEC. 904. OFFICE OF NATIONAL HEALTHCARE DISPARI-**  
 18                           **TIES AND QUALITY.**

19          “(a) IN GENERAL.—There is established within the  
 20          Agency an Office of National Healthcare Disparities and  
 21          Quality (referred to in this section as the ‘Office’). Such  
 22          Office shall administer the development and submission of  
 23          the annual National Healthcare Disparities Report (under  
 24          section 903(a)(6)) and the National Healthcare Quality

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

3 “(b) NATIONAL HEALTHCARE DISPARITIES AND  
4 QUALITY REPORTS.—

5 “(1) REPORTING REQUIREMENTS.—Not later  
6 than 1 year after the date of enactment of this sec-  
7 tion, and annually thereafter, the Office, in consulta-  
8 tion with the Advisory Committee under section 925,  
9 the Office of Minority Health, and the Office for  
10 Civil Rights of the Department of Health and  
11 Human Services, shall submit to the Secretary, the  
12 appropriate committees of Congress, and the pub-  
13 lic—

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

18 “(B) a report on general healthcare qual-  
19 ity.

20 “(2) LIMITATIONS.—The reports under para-  
21 graph (1) shall not identify individual hospitals or  
22 healthcare providers but shall include regional and  
23 State level data. To the maximum extent practicable,  
24 such reports shall—

1           “(A) indicate variations in healthcare qual-  
2           ity between States and regions; and

3           “(B) to the maximum extent practicable,  
4           include data reported by race, ethnicity, pri-  
5           mary language, and highest educational level  
6           attained in accordance with section 249.

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

10          “(4) AUTHORIZATION OF APPROPRIATIONS.—  
11          There is authorized to be appropriated to carry out  
12          this subsection, \$10,000,000 for each of fiscal years  
13          2005 through 2007, and such sums as may be nec-  
14          essary for each of fiscal years 2008 through 2015.

15          “(c) ACTIVITIES RELATING TO BEST PRACTICES.—

16          “(1) REPORT.—The Office of National  
17          Healthcare Disparities and Quality shall annually  
18          publish a report that describes the specific activities  
19          undertaken by Faircare Level I institutions, as des-  
20          ignated under section 330P of this Act or section  
21          1898(b) of the Social Security Act, that have re-  
22          sulted in a decrease in healthcare disparities or im-  
23          proved quality. Such reports shall include rec-  
24          ommendations for carrying out such activities at  
25          other healthcare institutions.

1           “(2) CONFERENCE.—In conjunction with the  
2           publication of each report under paragraph (1), Of-  
3           fice of National Healthcare Disparities and Quality  
4           shall hold an annual conference at which personnel  
5           from the Faircare institutions described in para-  
6           graph (1) can interact, advise, and consult with  
7           other healthcare institutions.

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

18          “(4) AUTHORIZATION OF APPROPRIATIONS.—  
19          There is authorized to be appropriated to carry out  
20          this subsection, \$5,000,000 for each of fiscal years  
21          2005 to 2007, and such sums as may be necessary  
22          for each of fiscal years 2008 through 2015.”.

1   **TITLE III—FAIRCARE HOSPITAL**  
2                   **PROGRAM**

3   **SEC. 301. FAIRCARE HOSPITAL PROGRAM.**

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

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

8               (A) determine which hospitals have suc-  
9 cessfully reduced healthcare disparities between  
10 health disparity populations and other patients  
11 and improved healthcare quality based on the  
12 Hospital Quality Initiative measures established  
13 by the Agency for Healthcare Research and  
14 Quality under part C of title IX of the Public  
15 Health Service Act, as added by title II;

16               (B) verify the accuracy of the data sub-  
17 mitted by such hospitals for purposes of being  
18 designated as a Faircare Hospital; and

19               (C) designate such hospitals as Faircare  
20 hospitals; and

21           (2) provide such hospitals with increased pay-  
22 ments under the medicare program.

23       (b) PROGRAM.—Title XVIII of the Social Security  
24 Act, as amended by section 1016 of the Medicare Prescrip-  
25 tion Drug, Improvement, and Modernization Act of 2003

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

3 “PERFORMANCE INCENTIVE PAYMENT PROGRAM

4 “SEC. 1898. (a) ESTABLISHMENT.—

5 “(1) IN GENERAL.—The Secretary shall estab-  
 6 lish a program under which financial incentive pay-  
 7 ments are made in accordance with subsection (c) to  
 8 subsection (d) hospitals (as defined in paragraph  
 9 (2)) that have been designated under subsection (b).

10 “(2) SUBSECTION (d) HOSPITAL.—In this sec-  
 11 tion, the term ‘subsection (d) hospital’ has the  
 12 meaning given that term in section 1886(d)(1)(B).

13 “(b) DESIGNATION OF FAIRCARE HOSPITALS.—

14 “(1) IN GENERAL.—For each of fiscal years  
 15 2006 through 2014, the Secretary shall designate  
 16 subsection (d) hospitals as follows:

17 “(A) LEVEL III FAIRCARE HOSPITAL.—The  
 18 Secretary shall designate a subsection (d) hos-  
 19 pital as a Level III Faircare hospital if the fol-  
 20 lowing requirements are met:

21 “(i) The subsection (d) hospital sub-  
 22 mitted data described in section 249 of the  
 23 Public Health Service Act and part C of  
 24 title IX of such Act to the Secretary in  
 25 such form and manner and at such time  
 26 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.



1 “(ii) The Secretary determines that  
2 the subsection (d) hospital, during the 24-  
3 month period preceding such determina-  
4 tion, has made a significant reduction in  
5 the disparities in the treatment of health  
6 disparity populations relative to other pa-  
7 tients for—

8 “(I) the majority of the applica-  
9 ble measures; or

10 “(II) all of the 25 percent high-  
11 est ranked applicable measures, as  
12 ranked for their importance for  
13 healthcare equity by the Agency for  
14 Healthcare Research and Quality  
15 under section 925 of the Public  
16 Health Service Act.

17 “(C) LEVEL I FAIRCARE HOSPITAL.—The  
18 Secretary shall designate a subsection (d) hos-  
19 pital as a Level I Faircare hospital if the fol-  
20 lowing requirements are met:

21 “(i) The requirement described in  
22 subparagraph (A)(i) is met.

23 “(ii) Either—

24 “(I) the requirement described in  
25 subparagraph (A)(ii) is met; or

1                   “(II) the Secretary determines  
2                   that the frequency of appropriate care  
3                   provided by the subsection (d) hos-  
4                   pital for each applicable measure is at  
5                   least 10 percentage points greater  
6                   than the national average for the fre-  
7                   quency of appropriate care for each  
8                   applicable measure.

9                   “(iii) The Secretary determines that  
10                  the subsection (d) hospital, during the 24-  
11                  month period preceding such determina-  
12                  tion, has had no significant disparity in the  
13                  treatment of health disparity populations  
14                  relative to other patients for all of the 75  
15                  percent highest ranked applicable meas-  
16                  ures, as ranked for their importance for  
17                  healthcare equity by the Agency for  
18                  Healthcare Research and Quality under  
19                  section 925 of the Public Health Service  
20                  Act.

21                  “(2) APPLICABLE MEASURES DEFINED.—For  
22                  purposes of this subsection, the term ‘applicable  
23                  measures’ means the Hospital Quality Initiative  
24                  measures established by the Agency for Healthcare

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

3 “(3) HEALTH DISPARITY POPULATION DE-  
4 FINED.—For purposes of this subsection, the term  
5 ‘health disparity population’ has the meaning given  
6 that term in section 485E(d) of the Public Health  
7 Service Act.

8 “(b) FINANCIAL INCENTIVE PAYMENTS.—

9 “(1) IN GENERAL.—Subject to paragraph (2)  
10 and subsection (d), for purposes of subclauses (XIX)  
11 and (XX) of section 1886(b)(3)(B)(i) for each of fis-  
12 cal years 2007 through 2015, in the case of a sub-  
13 section (d) hospital that has been designated under  
14 subsection (b) for a fiscal year, the Secretary shall  
15 increase the applicable percentage increase for the  
16 subsequent fiscal year for such hospital—

17 “(A) in the case of a Level I Faircare hos-  
18 pital, by 4 percentage points (or 8 percentage  
19 points in the case of such a hospital who is also  
20 described in subparagraph (B) of section  
21 1923(b)(1)(B));

22 “(B) in the case of a Level II Faircare  
23 hospital, by 2 percentage points (or 4 percent-  
24 age points in the case of such a hospital who

1 is also described in subparagraph (B) of section  
2 1923(b)(1)(B)); and

3 “(C) in the case of a Level III Faircare  
4 hospital, by 1 percentage point (or 2 percentage  
5 points in the case of such a hospital who is also  
6 described in subparagraph (B) of section  
7 1923(b)(1)(B)).

8 “(2) REDUCTION IN FINANCIAL INCENTIVE  
9 PAYMENTS IF INSUFFICIENT FUNDING AVAIL-  
10 ABLE.—If the Secretary estimates that the total  
11 amount of increased payments under paragraph (1)  
12 for a fiscal year will exceed the funding available  
13 under subsection (d) for such increased payments  
14 for the fiscal year, the Secretary shall proportion-  
15 ately reduce the percentage points described in sub-  
16 paragraphs (A), (B), and (C) of paragraph (1) in  
17 order to eliminate such excess.

18 “(3) INCREASED PAYMENT NOT BUILT INTO  
19 THE BASE.—Any increased payment under para-  
20 graph (1) shall only apply to the fiscal year involved  
21 and the Secretary shall not take into account any  
22 such increased payment in computing the applicable  
23 percentage increase under clause (i)(XIX) for a sub-  
24 sequent fiscal year.

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

5   **SEC. 302. TECHNICAL ASSISTANCE GRANTS.**

6       (a) IN GENERAL.—The Secretary of Health and  
7 Human Services shall provide technical assistance to eligi-  
8 ble entities for the conduct of demonstration projects to  
9 improve the quality of healthcare and to reduce healthcare  
10 disparities.

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

13               (1) be a hospital—

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

17                       (B) that provides care or treatment for a  
18 substantial number of patients who are unin-  
19 sured, are receiving assistance under a State  
20 program under title XIX of the Social Security  
21 Act, or are members of health disparity popu-  
22 lations, as determined by the Secretary; and

23                       (C)(i) with respect to which, not less than  
24 50 percent of the entity’s patient population is  
25 made up of racial and ethnic minorities; or

1                   (ii) that serves a disproportionate percent-  
2                   age of local, minority racial and ethnic patients,  
3                   or that has a patient population, at least 50  
4                   percent of which is limited English proficient;  
5                   and

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

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

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

18           (e) AUTHORIZATION OF APPROPRIATIONS.—There is  
19 authorized to be appropriated to carry out this section,  
20 such sums as may be necessary for each of fiscal years  
21 2005 through 2015.

1   **TITLE IV—COMMUNITY HEALTH**  
2                   **CENTERS**

3   **SEC. 401. AUTHORITY OF BUREAU OF PRIMARY HEALTH**  
4                   **CARE TO DEVELOP NEW REPORTING STAND-**  
5                   **ARDS.**

6       (a) IN GENERAL.—The Secretary of Health and  
7 Human Services, acting through the Bureau of Primary  
8 Health Care within the Health Resources and Services Ad-  
9 ministration, shall have the authority to—

10           (1) incorporate the outpatient measures of the  
11 Agency for Healthcare Research and Quality as de-  
12 veloped under part C of title IX of the Public Health  
13 Service Act (as added by title II) into a supplement  
14 to existing demographic or quality reporting instru-  
15 ments or other quality reporting instruments utilized  
16 by the Health Resources and Services Administra-  
17 tion;

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

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

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

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

3 **SEC. 402. FAIRCARE DESIGNATION FOR HEALTH CENTERS.**

4 Part P of title III of the Public Health Service Act  
5 (42 U.S.C. 280g et seq.) is amended by adding at the end  
6 the following:

7 **“SEC. 399P. FAIRCARE DESIGNATION FOR HEALTH CEN-**  
8 **TERS.**

9 “(a) DESIGNATION OF FAIRCARE HEALTH CEN-  
10 TERS.—

11 “(1) IN GENERAL.—For each of fiscal years  
12 2006 through 2014, the Secretary shall designate  
13 health centers that receive Federal assistance as fol-  
14 lows:

15 “(A) LEVEL III FAIRCARE HEALTH CEN-  
16 TER.—The Secretary shall designate a health  
17 center as a Level III Faircare health center if  
18 the following requirements are met:

19 “(i) The health center submitted data  
20 described in section 249 and part C of title  
21 IX to the Secretary in such form and man-  
22 ner and at such time specified by the Sec-  
23 retary under such section and part and all  
24 such data submitted relating to patient  
25 quality includes data on the race, ethnicity,



1 highest education level attained, and pri-  
2 mary language of such patients.

3 “(ii) The Secretary determines that  
4 the health center has improved the rate of  
5 delivery of high quality care during the 24-  
6 month period preceding such determina-  
7 tion. A health center shall be determined  
8 to meet the requirement in the preceding  
9 sentence if the Secretary determines that  
10 the health center has increased the fre-  
11 quency of appropriate care for the majority  
12 of the applicable measures during such 24-  
13 month period by at least 5 percentage  
14 points within each such measure.

15 “(B) LEVEL II FAIRCARE HEALTH CEN-  
16 TER.—The Secretary shall designate a health  
17 center as a Level II Faircare health center if  
18 the following requirements are met:

19 “(i) The requirements described in  
20 clauses (i) and (ii) of subparagraph (A)  
21 are met.

22 “(ii) The Secretary determines that  
23 the health center, during the 24-month pe-  
24 riod preceding such determination, has  
25 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 applica-  
ble measures; or

“(II) all of the 25 percent high-  
est 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 CEN-  
TER.—The Secretary shall designate a health  
center as a Level I Faircare health center if the  
following requirements are met:

“(i) The requirement described sub-  
paragraph (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 per-  
centage points greater than the na-  
tional average for the frequency of ap-

1                   appropriate care for each applicable  
2                   measure.

3                   “(iii) The Secretary determines that  
4                   the health center, during the 24-month pe-  
5                   riod preceding such determination, has had  
6                   no significant disparity in the treatment of  
7                   health disparity populations relative to  
8                   other patients for all of the 75 percent  
9                   highest ranked applicable measures, as  
10                  ranked for their importance for healthcare  
11                  equity by the Agency for Healthcare Re-  
12                  search and Quality under section 925.

13                  “(2) APPLICABLE MEASURES DEFINED.—For  
14                  purposes of this subsection, the term ‘applicable  
15                  measures’ means the measures determined applica-  
16                  ble under section 401(a) of the Faircare Act.

17                  “(3) HEALTH DISPARITY POPULATION DE-  
18                  FINED.—For purposes of this subsection, the term  
19                  ‘health disparity population’ has the meaning given  
20                  that term in section 485E(d).

21                  “(b) ELIGIBILITY FOR BONUSES.—A health center  
22                  that is designated as a Faircare health center under sub-  
23                  section (a) shall be eligible for the following annual bo-  
24                  nuses in the fiscal year following the year in which the  
25                  health center is designated as a Faircare health center

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

3 “(1) With respect to a health center that is des-  
4 ignated as a Level III Faircare health center, the  
5 Secretary shall determine the amount of such bonus  
6 which shall not be less than \$200,000.

7 “(2) With respect to a health center that is des-  
8 ignated as a Level II Faircare health center, the  
9 Secretary shall determine the amount of such bonus  
10 which shall not be less than \$300,000.

11 “(3) With respect to a health center that is des-  
12 ignated as a Level I Faircare health center, the Sec-  
13 retary shall determine the amount of such bonus  
14 which shall not be less than \$500,000.

15 “(c) REDUCTION IN FINANCIAL INCENTIVE PAY-  
16 MENTS IF INSUFFICIENT FUNDING AVAILABLE.—If the  
17 Secretary estimates that the total amount of bonuses  
18 under subsection (b) for a fiscal year will exceed the fund-  
19 ing available under subsection (e) for such bonuses for the  
20 fiscal year, the Secretary shall proportionately reduce the  
21 amount of the bonus payments described in paragraphs  
22 (1), (2), and (3) of subsection (b) in order to eliminate  
23 such excess.

24 “(d) DEFINITION.—For purposes of this section, the  
25 term ‘health center’ means a Federally qualified health

1 center as defined in section 1861(aa)(4) of the Social Se-  
 2 curity Act.

3 “(e) AUTHORIZATION OF APPROPRIATIONS.—There  
 4 is authorized to be appropriated to carry out this section,  
 5 such sums as may be necessary for each of fiscal years  
 6 2007 through 2015.”.

7 **SEC. 403. GRANTS FOR TECHNICAL ASSISTANCE.**

8 Part P of title III of the Public Health Service Act  
 9 (42 U.S.C. 280g et seq.), as amended by section 402, is  
 10 further amended by adding at the end the following:

11 **“SEC. 399Q. GRANTS FOR TECHNICAL ASSISTANCE IN IM-**  
 12 **PROVING QUALITY.**

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

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

1 may include competitively awarded grants and other forms  
2 of assistance.

3 “(c) USE OF ASSISTANCE.—Assistance provided  
4 under this section shall be used by the health center to  
5 improve healthcare quality or reduce healthcare dispari-  
6 ties.

7 “(d) DEFINITION.—For purposes of this section, the  
8 term ‘health center’ means a Federally qualified health  
9 center as defined in section 1861(aa)(4) of the Social Se-  
10 curity Act.

11 “(e) AUTHORIZATION OF APPROPRIATIONS.—There  
12 is authorized to be appropriated to carry out this sub-  
13 section, such sums as may be necessary for each of fiscal  
14 years 2007 through 2015.”.

15 **SEC. 404. HEALTH DISPARITY COLLABORATIVES.**

16 (a) IN GENERAL.—The Bureau of Primary Health  
17 Care within the Health Resources and Services Adminis-  
18 tration shall—

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

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

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

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

7 (c) DEFINITION.—For purposes of this section, the  
8 term ‘health center’ means a Federally qualified health  
9 center as defined in section 1861(aa)(4) of the Social Se-  
10 curity Act.

11 (d) AUTHORIZATION OF APPROPRIATIONS.—There is  
12 authorized to be appropriated to carry out this section,  
13 such sums as may be necessary for each of fiscal years  
14 2005 through 2015.

## 15 **TITLE V—REACH 2010**

### 16 **SEC. 501. EXPANSION OF REACH 2010.**

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

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

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

6           (2) prepare and submit to the Secretary of  
7           Health and Human Services an application at such  
8           time, in such manner, and containing such informa-  
9           tion as the Secretary may require.

10          (c) USE OF GRANTS.—Amounts provided under a  
11       grant under this section shall be used to support commu-  
12       nity coalitions in designing, implementing, and evaluating  
13       community-driven strategies to eliminate health dispari-  
14       ties, with an emphasis on African Americans, American  
15       Indians, Alaska Natives, Asian Americans, Hispanic  
16       Americans, and Pacific Islanders.

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

22               (1) Cardiovascular disease.

23               (2) Immunizations.

24               (3) Breast and cervical cancer screening and  
25       management.



1 (4) Diabetes.

2 (5) HIV/AIDS.

3 (6) Infant mortality.

4 (7) Asthma.

5 (8) Obesity.

6 (8) At the discretion of the Director of the Cen-  
 7 ters for Disease Control and Prevention, any addi-  
 8 tional priority areas determined appropriate by the  
 9 Agency for Healthcare Research and Quality in con-  
 10 sultation with the Advisory Committee established  
 11 under section 925 of the Public Health Service Act.

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

## 18 **TITLE VI—MALPRACTICE**

### 19 **INSURANCE RELIEF**

20 **SEC. 601. REFUNDABLE TAX CREDIT FOR THE COST OF**  
 21 **MALPRACTICE INSURANCE FOR CERTAIN**  
 22 **PROVIDERS.**

23 (a) IN GENERAL.—Subpart C of part IV of sub-  
 24 chapter A of chapter 1 of the Internal Revenue Code of  
 25 1986 (relating to refundable credits) is amended by redес-

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

3 **“SEC. 36. CERTAIN MALPRACTICE INSURANCE COSTS.**

4       “(a) IN GENERAL.—In the case of an eligible health  
5 care provider, there shall be allowed as a credit against  
6 the tax imposed by this subtitle for the taxable year an  
7 amount equal to the applicable percentage of qualified  
8 malpractice insurance expenditures paid or incurred dur-  
9 ing the taxable year.

10       “(b) APPLICABLE PERCENTAGE.—For purposes of  
11 this section—

12               “(1) IN GENERAL.—The applicable percentage  
13 shall be—

14                       “(A) 10 percent for any taxable year for  
15 which the person claiming the credit is an eligi-  
16 ble health care provider, plus

17                       “(B) 5 percent for each consecutive prior  
18 taxable year ending after the date of enactment  
19 of this section for which such person was an eli-  
20 gible health care provider.

21       “(2) LIMITATION.—The applicable percentage  
22 shall not exceed 25 percent.

23       “(c) ELIGIBLE HEALTH CARE PROVIDER.—For pur-  
24 poses of this section, the term ‘eligible health care pro-  
25 vider’ means—

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

3           “(A) located in a medically underserved  
4       area (as defined in section 1302(7) of the Pub-  
5       lic Health Service Act) or in a health profes-  
6       sional shortage area (as designated under sec-  
7       tion 332 of the Public Health Service Act), and

8           “(B) designated as a Level I Faircare Hos-  
9       pital under section 339P of the Public Health  
10      Service Act or section 1898 of the Social Secu-  
11      rity Act for the year in which such hospital’s  
12      taxable year ends, and

13          “(2) a physician for whom not less than 66 per-  
14      cent of the practice for the taxable year is at a facil-  
15      ity described in paragraph (1).

16      “(d) QUALIFIED MEDICAL MALPRACTICE INSUR-  
17      ANCE EXPENDITURE.—The term ‘qualified medical mal-  
18      practice insurance expenditure’ means so much of any pro-  
19      fessional insurance premium, surcharge, payment or other  
20      cost or expense required as a condition of State licensure  
21      which is incurred by an eligible health care provider in  
22      a taxable year for the sole purpose of providing or fur-  
23      nishing general medical malpractice liability insurance for  
24      such eligible health care provider.”.

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

5 “(d) CREDIT FOR MEDICAL MALPRACTICE LIABILITY  
6 INSURANCE PREMIUMS.—

7 “(1) IN GENERAL.—No deduction shall be al-  
8 lowed for that portion of the qualified medical mal-  
9 practice insurance expenditures otherwise allowable  
10 as a deduction for the taxable year which is equal  
11 to the amount of the credit allowable for the taxable  
12 year under section 36.

13 “(2) CONTROLLED GROUPS.—In the case of a  
14 corporation which is a member of a controlled group  
15 of corporations (within the meaning of section  
16 41(f)(5)) or a trade or business which is treated as  
17 being under common control with other trades or  
18 business (within the meaning of section  
19 41(f)(1)(B)), this subsection shall be applied under  
20 rules prescribed by the Secretary similar to the rules  
21 applicable under subparagraphs (A) and (B) of sec-  
22 tion 41(f)(1).”.

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

1 ed by inserting before the period “or from section 36 of  
2 such Code”.

3 (d) CLERICAL AMENDMENT.—The table of sections  
4 for subpart C of part IV of subchapter A of chapter 1  
5 of the Internal Revenue Code of 1986 is amended by strik-  
6 ing the item related to section 36 and inserting the fol-  
7 lowing new items:

“Sec. 36. Certain malpractice insurance costs.

“Sec. 37. Overpayments of tax.”.

8 (e) EFFECTIVE DATE.—The amendments made by  
9 this section shall apply to expenditures incurred after De-  
10 cember 31, 2005.

11 (f) AVAILABILITY OF CREDIT FOR TAX EXEMPT OR-  
12 GANIZATIONS.—The Secretary of the Treasury shall ad-  
13 minister the credit allowable under section 36 of the Inter-  
14 nal Revenue Code of 1986 (as added by this section) in  
15 such a manner so as to minimize to the largest extent pos-  
16 sible the administrative burden on tax exempt organiza-  
17 tions claiming the credit.

18 **SEC. 602. GRANTS TO NON-PROFIT HOSPITALS.**

19 (a) IN GENERAL.—The Secretary of Health and  
20 Human Services, acting through the Administrator of the  
21 Health Resources and Services Administration, shall  
22 award grants to eligible entities to assist such entities in  
23 defraying qualified medical malpractice insurance expendi-  
24 tures.

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

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

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

8 (3) prepare and submit to the Secretary of  
9 Health and Human Services an application at such  
10 time, in such manner, and containing such informa-  
11 tion as the Secretary may require.

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

14 (1) with respect to the first year of the grant,  
15 an amount equal to 10 percent of the qualified med-  
16 ical malpractice insurance expenditures of the entity  
17 for the year;

18 (2) with respect to the second year of the grant,  
19 an amount equal to 15 percent of the qualified med-  
20 ical malpractice insurance expenditures of the entity  
21 for the year;

22 (3) with respect to the third year of the grant,  
23 an amount equal to 20 percent of the qualified med-  
24 ical malpractice insurance expenditures of the entity  
25 for the year; and

1           (4) with respect to the fourth and subsequent  
2       years of the grant, an amount equal to 25 percent  
3       of the qualified medical malpractice insurance ex-  
4       penditures of the entity for the year.

5       (d) DEFINITION.—In this section, the term “qualified  
6       medical malpractice insurance expenditure” has the mean-  
7       ing given such term in section 36(d) of the Internal Rev-  
8       enue Code of 1986.

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

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

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

1 **SEC. 604. AUTHORIZATION OF APPROPRIATIONS.**

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

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