

108TH CONGRESS
2D SESSION

S. 2594

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 SENATE OF THE UNITED STATES

JUNE 24, 2004

Mr. LIEBERMAN introduced the following bill; which was read twice and referred to the Committee on Finance

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 essential for eliminating disparities in health
2 and healthcare; and

3 “(G) develop quality assurance systems de-
4 signed to track disparities and quality improve-
5 ment systems designed to eliminate disparities.

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

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

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

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

21 “(1) under the Social Security Act (42 U.S.C.
22 301 et seq.) that pays for healthcare and services;
23 and

24 “(2) under this Act that provides Federal finan-
25 cial assistance for healthcare, biomedical research,

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-

1 tion and part and all such data submitted
2 relating to patient quality includes data on
3 the race, ethnicity, highest education level
4 attained, and primary language of such pa-
5 tients.

6 “(ii) The Secretary determines that
7 the subsection (d) hospital has improved
8 the rate of delivery of high quality care
9 during the 24-month period preceding such
10 determination. A hospital shall be deter-
11 mined to meet the requirement in the pre-
12 ceding sentence if the Secretary determines
13 that the hospital has increased the fre-
14 quency of appropriate care for the majority
15 of the applicable measures during such 24-
16 month period by at least 5 percentage
17 points within each such measure.

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

22 “(i) The requirements described in
23 clauses (i) and (ii) of subparagraph (A)
24 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 sub-
 22 paragraph (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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