

113TH CONGRESS
1ST SESSION

H. R. 2957

To amend the Public Health Service Act and the Social Security Act to extend health information technology assistance eligibility to behavioral health, mental health, and substance abuse professionals and facilities, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

AUGUST 1, 2013

Mr. MURPHY of Pennsylvania (for himself, Mr. BARBER, Mr. ROE of Tennessee, Mr. BURGESS, Mr. CASSIDY, Mr. DENT, Mr. TIBERI, Mrs. BLACKBURN, Mr. GUTHRIE, Mr. BUCSHON, and Mr. MARINO) 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

A BILL

To amend the Public Health Service Act and the Social Security Act to extend health information technology assistance eligibility to behavioral health, mental health, and substance abuse professionals and facilities, and for other purposes.

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.**

2 This Act may be cited as the “Behavioral Health In-
3 formation Technology Act of 2013”.

4 **SEC. 2. EXTENSION OF HEALTH INFORMATION TECH-**
5 **NOLOGY ASSISTANCE FOR BEHAVIORAL AND**
6 **MENTAL HEALTH AND SUBSTANCE ABUSE.**

7 Section 3000(3) of the Public Health Service Act (42
8 U.S.C. 300jj(3)) is amended by inserting before “and any
9 other category” the following: “behavioral and mental
10 health professionals (as defined in section
11 331(a)(3)(E)(i)), a substance abuse professional, a psy-
12 chiatric hospital (as defined in section 1861(f) of the So-
13 cial Security Act), a community mental health center
14 meeting the criteria specified in section 1913(c), a residen-
15 tial or outpatient mental health or substance abuse treat-
16 ment facility,”.

17 **SEC. 3. EXTENSION OF ELIGIBILITY FOR MEDICARE AND**
18 **MEDICAID HEALTH INFORMATION TECH-**
19 **NOLOGY IMPLEMENTATION ASSISTANCE.**

20 (a) PAYMENT INCENTIVES FOR ELIGIBLE PROFES-
21 SIONALS UNDER MEDICARE.—Section 1848 of the Social
22 Security Act (42 U.S.C. 1395w–4) is amended—

23 (1) in subsection (a)(7)—

24 (A) in subparagraph (E), by adding at the
25 end the following new clause:

1 “(iv) ADDITIONAL ELIGIBLE PROFES-
2 SIONAL.—The term ‘additional eligible pro-
3 fessional’ means a clinical psychologist pro-
4 viding qualified psychologist services (as
5 defined in section 1861(ii)).”; and

6 (B) by adding at the end the following new
7 subparagraph:

8 “(F) APPLICATION TO ADDITIONAL ELIGI-
9 BLE PROFESSIONALS.—The Secretary shall
10 apply the provisions of this paragraph with re-
11 spect to an additional eligible professional in
12 the same manner as such provisions apply to an
13 eligible professional, except in applying sub-
14 paragraph (A)—

15 “(i) in clause (i), the reference to
16 2015 shall be deemed a reference to 2019;

17 “(ii) in clause (ii), the references to
18 2015, 2016, and 2017 shall be deemed ref-
19 erences to 2019, 2020, and 2021, respec-
20 tively; and

21 “(iii) in clause (iii), the reference to
22 2018 shall be deemed a reference to
23 2022.”; and

24 (2) in subsection (o)—

1 (A) in paragraph (5), by adding at the end
2 the following new subparagraph:

3 “(D) ADDITIONAL ELIGIBLE PROFES-
4 SIONAL.—The term ‘additional eligible profes-
5 sional’ means a clinical psychologist providing
6 qualified psychologist services (as defined in
7 section 1861(ii)).”; and

8 (B) by adding at the end the following new
9 paragraph:

10 “(6) APPLICATION TO ADDITIONAL ELIGIBLE
11 PROFESSIONALS.—The Secretary shall apply the
12 provisions of this subsection with respect to an addi-
13 tional eligible professional in the same manner as
14 such provisions apply to an eligible professional, ex-
15 cept in applying—

16 “(A) paragraph (1)(A)(ii), the reference to
17 2016 shall be deemed a reference to 2020;

18 “(B) paragraph (1)(B)(ii), the references
19 to 2011 and 2012 shall be deemed references to
20 2015 and 2016, respectively;

21 “(C) paragraph (1)(B)(iii), the references
22 to 2013 shall be deemed references to 2017;

23 “(D) paragraph (1)(B)(v), the references
24 to 2014 shall be deemed references to 2018;
25 and

1 “(E) paragraph (1)(E), the reference to
2 2011 shall be deemed a reference to 2015.”.

3 (b) ELIGIBLE HOSPITALS.—Section 1886 of the So-
4 cial Security Act (42 U.S.C. 1395ww) is amended—

5 (1) in subsection (b)(3)(B)(ix), by adding at the
6 end the following new subclause:

7 “(V) The Secretary shall apply
8 the provisions of this subsection with
9 respect to an additional eligible hos-
10 pital (as defined in subsection
11 (n)(6)(C)) in the same manner as
12 such provisions apply to an eligible
13 hospital, except in applying—

14 “(aa) subclause (I), the ref-
15 erences to 2015, 2016, and 2017
16 shall be deemed references to
17 2019, 2020, and 2021, respec-
18 tively; and

19 “(bb) subclause (III), the
20 reference to 2015 shall be
21 deemed a reference to 2019.”;
22 and

23 (2) in subsection (n)—

24 (A) in paragraph (6), by adding at the end
25 the following new subparagraph:

1 “(C) ADDITIONAL ELIGIBLE HOSPITAL.—

2 The term ‘additional eligible hospital’ means an
3 inpatient hospital that is a psychiatric hospital
4 (as defined in section 1861(f)).”; and

5 (B) by adding at the end the following new
6 paragraph:

7 “(7) APPLICATION TO ADDITIONAL ELIGIBLE
8 HOSPITALS.—The Secretary shall apply the provi-
9 sions of this subsection with respect to an additional
10 eligible hospital in the same manner as such provi-
11 sions apply to an eligible hospital, except in apply-
12 ing—

13 “(A) paragraph (2)(E)(ii), the references
14 to 2013 and 2015 shall be deemed references to
15 2017 and 2019, respectively; and

16 “(B) paragraph (2)(G)(i), the reference to
17 2011 shall be deemed a reference to 2015.”.

18 (c) MEDICAID PROVIDERS.—Section 1903(t) of the
19 Social Security Act (42 U.S.C. 1396b(t)) is amended—

20 (1) in paragraph (2)(B)—

21 (A) in clause (i), by striking “, or” and in-
22 serting a semicolon;

23 (B) in clause (ii), by striking the period
24 and inserting a semicolon; and

1 (C) by adding after clause (ii) the following
2 new clauses:

3 “(iii) a public hospital that is prin-
4 cipally a psychiatric hospital (as defined in
5 section 1861(f));

6 “(iv) a private hospital that is prin-
7 cipally a psychiatric hospital (as defined in
8 section 1861(f)) and that has at least 10
9 percent of its patient volume (as estimated
10 in accordance with a methodology estab-
11 lished by the Secretary) attributable to in-
12 dividuals receiving medical assistance
13 under this title;

14 “(v) a community mental health cen-
15 ter meeting the criteria specified in section
16 1913(c) of the Public Health Service Act;
17 or

18 “(vi) a residential or outpatient men-
19 tal health or substance abuse treatment fa-
20 cility that—

21 “(I) is accredited by the Joint
22 Commission on Accreditation of
23 Healthcare Organizations, the Com-
24 mission on Accreditation of Rehabili-
25 tation Facilities, the Council on Ac-

1 creditation, or any other national ac-
2 crediting agency recognized by the
3 Secretary; and

4 “(II) has at least 10 percent of
5 its patient volume (as estimated in ac-
6 cordance with a methodology estab-
7 lished by the Secretary) attributable
8 to individuals receiving medical assist-
9 ance under this title.”; and

10 (2) in paragraph (3)(B)—

11 (A) in clause (iv), by striking “and” after
12 the semicolon;

13 (B) in clause (v), by striking the period
14 and inserting “; and”; and

15 (C) by adding at the end the following new
16 clause:

17 “(vi) clinical psychologist providing
18 qualified psychologist services (as defined
19 in section 1861(ii)), if such clinical psy-
20 chologist is practicing in an outpatient
21 clinic that—

22 “(I) is led by a clinical psycholo-
23 gist; and

24 “(II) is not otherwise receiving
25 payment under paragraph (1) as a

1 Medicaid provider described in para-
2 graph (2)(B).”.

3 (d) MEDICARE ADVANTAGE ORGANIZATIONS.—Sec-
4 tion 1853 of the Social Security Act (42 U.S.C. 1395w-
5 23) is amended—

6 (1) in subsection (l)—

7 (A) in paragraph (1)—

8 (i) by inserting “or additional eligible
9 professionals (as described in paragraph
10 (9))” after “paragraph (2)”; and

11 (ii) by inserting “and additional eligi-
12 ble professionals” before “under such sec-
13 tions”;

14 (B) in paragraph (3)(B)—

15 (i) in clause (i) in the matter pre-
16 ceding subclause (I), by inserting “or an
17 additional eligible professional described in
18 paragraph (9)” after “paragraph (2)”; and

19 (ii) in clause (ii)—

20 (I) in the matter preceding sub-
21 clause (I), by inserting “or an addi-
22 tional eligible professional described in
23 paragraph (9)” after “paragraph
24 (2)”; and

1 (II) in subclause (I), by inserting
2 “or an additional eligible professional,
3 respectively,” after “eligible profes-
4 sional”;

5 (C) in paragraph (3)(C), by inserting “and
6 additional eligible professionals” after “all eligi-
7 ble professionals”;

8 (D) in paragraph (4)(D), by adding at the
9 end the following new sentence: “In the case
10 that a qualifying MA organization attests that
11 not all additional eligible professionals of the
12 organization are meaningful EHR users with
13 respect to an applicable year, the Secretary
14 shall apply the payment adjustment under this
15 paragraph based on the proportion of all such
16 additional eligible professionals of the organiza-
17 tion that are not meaningful EHR users for
18 such year.”;

19 (E) in paragraph (6)(A), by inserting
20 “and, as applicable, each additional eligible pro-
21 fessional described in paragraph (9)” after
22 “paragraph (2)”;

23 (F) in paragraph (6)(B), by inserting
24 “and, as applicable, each additional eligible hos-

1 pital described in paragraph (9)” after “sub-
2 section (m)(1)”;

3 (G) in paragraph (7)(A), by inserting
4 “and, as applicable, additional eligible profes-
5 sionals” after “eligible professionals”;

6 (H) in paragraph (7)(B), by inserting
7 “and, as applicable, additional eligible profes-
8 sionals” after “eligible professionals”;

9 (I) in paragraph (8)(B), by inserting “and
10 additional eligible professionals described in
11 paragraph (9)” after “paragraph (2)”; and

12 (J) by adding at the end the following new
13 paragraph:

14 “(9) ADDITIONAL ELIGIBLE PROFESSIONAL DE-
15 SCRIBED.—With respect to a qualifying MA organi-
16 zation, an additional eligible professional described
17 in this paragraph is an additional eligible profes-
18 sional (as defined for purposes of section 1848(o))
19 who—

20 “(A)(i) is employed by the organization; or

21 “(ii)(I) is employed by, or is a partner of,
22 an entity that through contract with the organi-
23 zation furnishes at least 80 percent of the enti-
24 ty’s Medicare patient care services to enrollees
25 of such organization; and

1 “(II) furnishes at least 80 percent of the
2 professional services of the additional eligible
3 professional covered under this title to enrollees
4 of the organization; and

5 “(B) furnishes, on average, at least 20
6 hours per week of patient care services.”; and
7 (2) in subsection (m)—

8 (A) in paragraph (1)—

9 (i) by inserting “or additional eligible
10 hospitals (as described in paragraph (7))”
11 after “paragraph (2)”; and

12 (ii) by inserting “and additional eligi-
13 ble hospitals” before “under such sec-
14 tions”;

15 (B) in paragraph (3)(A)(i), by inserting
16 “or additional eligible hospital” after “eligible
17 hospital”;

18 (C) in paragraph (3)(A)(ii), by inserting
19 “or an additional eligible hospital” after “eligi-
20 ble hospital” in each place it occurs;

21 (D) in paragraph (3)(B)—

22 (i) in clause (i), by inserting “or an
23 additional eligible hospital described in
24 paragraph (7)” after “paragraph (2)”; and

25 (ii) in clause (ii)—

1 (I) in the matter preceding sub-
2 clause (I), by inserting “or an addi-
3 tional eligible hospital described in
4 paragraph (7)” after “paragraph
5 (2)”; and

6 (II) in subclause (I), by inserting
7 “or an additional eligible hospital, re-
8 spectively,” after “eligible hospital”;

9 (E) in paragraph (4)(A), by inserting “or
10 one or more additional eligible hospitals (as de-
11 fined in section 1886(n)), as appropriate,” after
12 “section 1886(n)(6)(A)”;

13 (F) in paragraph (4)(D), by adding at the
14 end the following new sentence: “In the case
15 that a qualifying MA organization attests that
16 not all additional eligible hospitals of the orga-
17 nization are meaningful EHR users with re-
18 spect to an applicable period, the Secretary
19 shall apply the payment adjustment under this
20 paragraph based on the methodology specified
21 by the Secretary, taking into account the pro-
22 portion of such additional eligible hospitals, or
23 discharges from such hospitals, that are not
24 meaningful EHR users for such period.”;

1 (G) in paragraph (5)(A), by inserting
 2 “and, as applicable, each additional eligible hos-
 3 pital described in paragraph (7)” after “para-
 4 graph (2)”;

5 (H) in paragraph (5)(B), by inserting
 6 “and additional eligible hospitals, as applica-
 7 ble,” after “eligible hospitals”;

8 (I) in paragraph (6)(B), by inserting “and
 9 additional eligible hospitals described in para-
 10 graph (7)” after “paragraph (2)”; and

11 (J) by adding at the end the following new
 12 paragraph:

13 “(7) ADDITIONAL ELIGIBLE HOSPITAL DE-
 14 SCRIBED.—With respect to a qualifying MA organi-
 15 zation, an additional eligible hospital described in
 16 this paragraph is an additional eligible hospital (as
 17 defined in section 1886(n)(6)(C)) that is under com-
 18 mon corporate governance with such organization
 19 and serves individuals enrolled under an MA plan of-
 20 fered by such organization.”.

21 **SEC. 4. PROVIDING PROTECTIONS FOR CERTAIN PRO-**
 22 **VIDERS, VENDORS, AND USERS OF CERTIFIED**
 23 **EHR TECHNOLOGY.**

24 (a) COVERED ENTITIES.—

1 (1) COVERED ENTITIES.—For purposes of this
2 section, a covered entity means, with respect to cer-
3 tified EHR technology (as defined in section
4 1848(o)(4) of the Social Security Act (42 U.S.C.
5 1395w-4(o)(4))) and a year, any of the following:

6 (A) MEANINGFUL EHR USERS.—

7 (i) An eligible professional (as defined
8 in paragraph (5)(C) of section 1848(o) of
9 the Social Security Act (42 U.S.C. 1395w-
10 4(o))) determined to be a meaningful EHR
11 user under paragraph (2) of such section
12 for the EHR reporting period (as defined
13 in paragraph (5)(B) of such section) dur-
14 ing such year, or an additional eligible pro-
15 fessional (as defined in paragraph (5)(D)
16 of such section) determined to be a mean-
17 ingful EHR user pursuant to paragraph
18 (6) of such section for the EHR reporting
19 period (as defined in paragraph (5)(B) of
20 such section) during such year.

21 (ii) In the case of a qualifying MA or-
22 ganization (as defined in paragraph (5) of
23 section 1853(l) of such Act (42 U.S.C.
24 1395w-23(l))), an eligible professional de-
25 scribed in paragraph (2) of such section or,

1 as applicable, an additional eligible profes-
2 sional described in paragraph (9) of such
3 section of the organization who the organi-
4 zation attests under paragraph (6) of such
5 section to be a meaningful EHR user for
6 such year.

7 (iii) In the case of a qualifying MA
8 organization (as so defined), an eligible
9 hospital described in section 1853(m)(2) of
10 such Act (42 U.S.C. 1395w-23(m)(2)) or,
11 as applicable, an additional eligible hospital
12 described in section 1853(m)(7) of such
13 Act (42 U.S.C. 1395w-23(m)(7)) of the
14 organization which attests under section
15 1853(l)(6) of such Act (42 U.S.C. 1395w-
16 23(l)(6)) to be a meaningful EHR user for
17 the applicable period with respect to such
18 year.

19 (iv) An eligible hospital (as defined in
20 paragraph (6)(B) of section 1886(n) of
21 such Act (42 U.S.C. 1395ww(n)) deter-
22 mined to be a meaningful EHR user under
23 paragraph (3) of such section for the EHR
24 reporting period (as defined in paragraph
25 (6)(A) of such section) with respect to

1 such year, or an additional eligible hospital
2 (as defined in paragraph (6)(C) of such
3 section) determined to be a meaningful
4 EHR user under paragraph (7) of such
5 section for the EHR reporting period (as
6 defined in paragraph (6)(A) of such sec-
7 tion) with respect to such year.

8 (v) A critical access hospital deter-
9 mined pursuant to section 1814(l)(3) of
10 such Act (42 U.S.C. 1395f(l)(3)) to be a
11 meaningful EHR user (as would be deter-
12 mined under paragraph (3) of section
13 1886(n) of such Act (42 U.S.C.
14 1395ww(n))) for an EHR reporting period
15 (as defined in paragraph (6)(A) of such
16 section) for a cost reporting period begin-
17 ning during such year.

18 (vi) A Medicaid provider (as defined
19 in paragraph (2) of section 1903(t) of such
20 Act (42 U.S.C. 1396b(t))) eligible for pay-
21 ments described in paragraph (1) of such
22 section for such year.

23 (B) HEALTH INFORMATION EXCHANGE
24 ENTITIES.—Individuals and entities (other than
25 States or State designated entities) which dur-

1 ing such year are health information exchange
2 contractors (consisting of technology providers),
3 health information exchange participants (con-
4 sisting of organizations providing supportive
5 technology to a health information exchange),
6 and other users of health information exchanges
7 (consisting of other entities that may be ex-
8 changing clinical or administrative data). Man-
9 ufacturers of electronic health record (EHR)
10 software and other health information tech-
11 nologies who participate in the reporting of ad-
12 verse events or who otherwise contribute rel-
13 evant patient safety work product under sub-
14 section (b)(1).

15 (C) CERTAIN OTHER EHR USERS.—A
16 health care professional who, during such
17 year—

18 (i) is a user of such certified EHR
19 technology;

20 (ii) is not eligible for incentive pay-
21 ments based on meaningful use of such
22 technology under title XVIII or XIX of the
23 Social Security Act solely because the pro-
24 fessional is not—

1 (I) an eligible professional (as de-
2 fined in paragraph (5)(C) of section
3 1848(o) of such Act (42 U.S.C.
4 1395w-4(o)));

5 (II) an eligible professional de-
6 scribed in paragraph (2) of section
7 1853(l) of such Act (42 U.S.C.
8 1395w-23(l)) or, as applicable, an ad-
9 ditional eligible professional described
10 in paragraph (9) of such section, with
11 respect to a qualifying MA organiza-
12 tion (as defined in paragraph (5) of
13 such section);

14 (III) an eligible hospital de-
15 scribed in paragraph (2) of section
16 1853(m) of such Act (42 U.S.C.
17 1395w-23(m)) or, as applicable, an
18 additional eligible hospital described
19 in paragraph (7) of such section, with
20 respect to such a qualifying MA orga-
21 nization;

22 (IV) an eligible hospital (as de-
23 fined in paragraph (6)(B) of section
24 1886(n) of such Act (42 U.S.C.
25 1395ww(n)));

1 (V) a critical access hospital;

2 (VI) a Medicaid provider (as de-
3 fined in paragraph (2) of section
4 1903(t) of such Act (42 U.S.C.
5 1396b(t)));

6 (VII) an additional eligible pro-
7 fessional (as defined in paragraph
8 (5)(D) of section 1848(o) of such Act
9 (42 U.S.C. 1395w-4(o))); or

10 (VIII) an additional eligible hos-
11 pital (as defined in paragraph (6)(C)
12 of section 1886(n) of such Act (42
13 U.S.C. 1395ww(n))); and

14 (iii) attests, to the satisfaction of the
15 Secretary of Health and Human Services,
16 that but for the reason described in clause
17 (ii), the professional would otherwise sat-
18 isfy criteria to be eligible for such incentive
19 payments during such year.

20 (b) IMPROVING PATIENT SAFETY THROUGH ERROR
21 REPORTING AND REMEDIATION, AND CLARIFICATION OF
22 AUTHORITY.—

23 (1) QUARTERLY REPORTING BY PATIENT SAFE-
24 TY ORGANIZATIONS.—Paragraph (1) of section
25 924(b) of the Public Health Service Act (42 U.S.C.

299b–24) is amended by adding at the end the following:

“(H) Not less than quarterly each year, the entity shall submit to the Office of the National Coordinator findings that—

“(i) exclude any individually identifiable information;

“(ii) are based on information submitted to the entity by covered entities (as defined in section 4(a)(1) of the Behavioral Health Information Technology Act of 2013);

“(iii) describe the number and nature of EHR-related adverse events with respect to certified EHR technology (as such terms are defined in section 4(e) of such Act) so reported; and

“(iv) for each such EHR-related adverse event, identify the type event and the type electronic health record involved.”.

(2) APPLICATION OF SAFETY ORGANIZATION

PRIVILEGE AND CONFIDENTIALITY PROTECTIONS.—

In the case of a covered entity that submits to a patient safety organization information on an EHR-related adverse event with respect to certified EHR

1 technology, and in the case of the collection and
2 maintenance of such information by a patient safety
3 organization, the provisions of section 922 of the
4 Public Health Service Act (42 U.S.C. 299b–22)
5 shall apply to such information and to the organiza-
6 tion and the entity in the same manner such provi-
7 sions apply to patient safety work product and a pa-
8 tient safety organization and provider under part C
9 of title IX of such Act (42 U.S.C. 299b–2 et seq.).

10 (3) CLARIFICATION OF AUTHORITY.—Certified
11 EHR technology shall not be considered to be a de-
12 vice for purposes of the Federal Food, Drug, and
13 Cosmetic Act (21 U.S.C. 301 et seq.).

14 (c) RULES RELATING TO E-DISCOVERY.—In any
15 health care lawsuit against a covered entity that is related
16 to an EHR-related adverse event, with respect to certified
17 EHR technology used or provided by the covered entity,
18 electronic discovery shall be limited to—

19 (1) information that is related to such EHR-re-
20 lated adverse event; and

21 (2) information from the period in which such
22 EHR-related adverse event occurred.

23 (d) LEGAL PROTECTIONS FOR COVERED ENTI-
24 TIES.—

1 (1) GENERAL.—For a covered entity described
2 in subsection (a), the following protections apply:

3 (A) ENCOURAGING SPEEDY RESOLUTION
4 OF CLAIMS.—

5 (i) GENERAL.—A claimant may not
6 commence a health care lawsuit against a
7 covered entity on any date that is 3 years
8 after the date of manifestation of injury or
9 1 year after the claimant discovers, or
10 through the use of reasonable diligence
11 should have discovered, the injury, which-
12 ever occurs first. This limitation shall be
13 tolled to the extent that the claimant is
14 able to prove—

15 (I) fraud;

16 (II) intentional concealment; or

17 (III) the presence of a foreign
18 body, which has no therapeutic or di-
19 agnostic purpose or effect, in the per-
20 son of the injured person.

21 (ii) TREATMENT OF A MINOR.—A
22 health care lawsuit by or on behalf of a
23 claimant under the age of 17 years at the
24 time the injury was suffered may not be
25 commenced after the date that is 3 years

1 after the date of the alleged manifestation
2 of injury except that actions by a claimant
3 under the age of 6 years may not be com-
4 menced after the date that is 3 years after
5 the date of manifestation of injury or prior
6 to the claimant's 8th birthday, whichever
7 provides a longer period. This limitation
8 shall be tolled for claimants under the age
9 of 17 years for any period during which a
10 parent or guardian and a health care pro-
11 vider or health care organization have com-
12 mitted fraud or collusion in the failure to
13 bring an action on behalf of the claimant.

14 (B) EQUITABLE ASSIGNMENT OF RESPON-
15 SIBILITY.—In any health care lawsuit against a
16 covered entity—

17 (i) each party to the lawsuit other
18 than the claimant that is such a covered
19 entity shall be liable for that party's sev-
20 eral share of any damages only and not for
21 the share of any other person and such
22 several share shall be in direct proportion
23 to that party's proportion of responsibility
24 for the injury, as determined under clause
25 (iii);

1 (ii) whenever a judgment of liability is
2 rendered as to any such party, a separate
3 judgment shall be rendered against each
4 such party for the amount allocated to
5 such party; and

6 (iii) for purposes of this subpara-
7 graph, the trier of fact shall determine the
8 proportion of responsibility of each such
9 party for the claimant's harm.

10 (C) SUBSEQUENT REMEDIAL MEASURES.—

11 Evidence of subsequent remedial measures to
12 an EHR-related adverse event with respect to
13 certified EHR technology used or provided by
14 the covered entity (including changes to the cer-
15 tified EHR system, additional training require-
16 ments, or changes to standard operating proce-
17 dures) by a covered entity shall not be admis-
18 sible in health care lawsuits.

19 (D) INCREASED BURDEN OF PROOF PRO-
20 TECTION FOR COVERED ENTITIES.—Punitive
21 damages may, if otherwise permitted by appli-
22 cable State or Federal law, be awarded against
23 any covered entity in a health care lawsuit only
24 if it is proven by clear and convincing evidence
25 that such entity acted with reckless disregard

1 for the health or safety of the claimant. In any
2 such health care lawsuit where no judgment for
3 compensatory damages is rendered against such
4 entity, no punitive damages may be awarded
5 with respect to the claim in such lawsuit.

6 (E) PROTECTION FROM LIBEL OR SLAN-
7 DER.—Covered entities and employees, agents
8 and representatives of covered entities are im-
9 mune from civil action for libel or slander aris-
10 ing from information or entries made in cer-
11 tified EHR technology and for the transfer of
12 such information to another eligible provider,
13 hospital or health information exchange, if the
14 information, transfer of information, or entries
15 were made in good faith and without malice.

16 (e) DEFINITIONS.—In this section:

17 (1) CLAIMANT.—The term “claimant” means
18 any person who brings a health care lawsuit, includ-
19 ing a person who asserts or claims a right to legal
20 or equitable contribution, indemnity, or subrogation,
21 arising out of a health care liability claim or action,
22 and any person on whose behalf such a claim is as-
23 serted or such an action is brought, whether de-
24 ceased, incompetent, or a minor.

1 (2) COMPENSATORY DAMAGES.—The term
2 “compensatory damages” means objectively
3 verifiable monetary losses incurred as a result of the
4 provisions of, use of, or payment for (or failure to
5 provide, use, or pay for) health care services or med-
6 ical products, such as past and future medical ex-
7 penses, loss of past and future earnings, cost of ob-
8 taining domestic services, loss of employment, and
9 loss of business or employment opportunities, dam-
10 ages for physical and emotional pain, suffering, in-
11 convenience, physical impairment, mental anguish,
12 disfigurement, loss of enjoyment in life, loss of soci-
13 ety and companionship, loss of consortium (other
14 than loss of domestic service), hedonic damages, in-
15 jury to reputation, and all other nonpecuniary losses
16 of any kind or nature. Such term includes economic
17 damages and noneconomic damages, as such terms
18 are defined in this subsection.

19 (3) ECONOMIC DAMAGES.—The term “economic
20 damages” means objectively verifiable monetary
21 losses incurred as a result of the provisions of, use
22 of, or payment for (or failure to provide, use, or pay
23 for) health care services or medical products, such as
24 past and future medical expenses, loss of past and
25 future earnings, cost of obtaining domestic services,

1 loss of employment, and loss of business or employ-
2 ment opportunities.

3 (4) CERTIFIED EHR TECHNOLOGY.—The term
4 “certified EHR technology” has the meaning given
5 such term in section 1848(o)(4) of the Social Secu-
6 rity Act (42 U.S.C. 1395w–4(o)(4)).

7 (5) EHR-RELATED ADVERSE EVENT.—The
8 term “EHR-related adverse event” means, with re-
9 spect to a provider, a defect, malfunction, or error
10 in the certified health information technology or
11 electronic health record used by the provider, or in
12 the input or output of data maintained through such
13 technology or record, that results or could reason-
14 ably result in harm to a patient.

15 (6) HEALTH CARE LAWSUIT.—The term
16 “health care lawsuit” means any health care liability
17 claim concerning the provision of health care items
18 or services or any medical product affecting inter-
19 state commerce, or any health care liability action
20 concerning the provision of health care items or
21 services or any medical product affecting interstate
22 commerce, brought in a State or Federal court or
23 pursuant to an alternative dispute resolution system,
24 against a health care provider, a health care organi-
25 zation, or the manufacturer, distributor, supplier,

1 marketer, promoter, or seller of a medical product,
2 regardless of the theory of liability on which the
3 claim is based, or the number of claimants, plain-
4 tiffs, defendants, or other parties, or the number of
5 claims or causes of action, in which the claimant al-
6 leges a health care liability claim. Such term does
7 not include a claim or action which is based on
8 criminal liability; which seeks civil fines or penalties
9 paid to Federal, State, or local government; or which
10 is grounded in antitrust.

11 (7) HEALTH CARE LIABILITY ACTION.—The
12 term “health care liability action” means a civil ac-
13 tion brought in a State or Federal court or pursuant
14 to an alternative dispute resolution system, against
15 a health care provider, a health care organization, or
16 the manufacturer, distributor, supplier, marketer,
17 promoter, or seller of a medical product, regardless
18 of the theory of liability on which the claim is based,
19 or the number of plaintiffs, defendants, or other par-
20 ties, or the number of causes of action, in which the
21 claimant alleges a health care liability claim.

22 (8) HEALTH CARE LIABILITY CLAIM.—The
23 term “health care liability claim” means a demand
24 by any person, whether or not pursuant to alter-
25 native dispute resolution, against a health care pro-

1 vider, health care organization, or the manufacturer,
2 distributor, supplier, marketer, promoter, or seller of
3 a medical product, including third-party claims,
4 cross-claims, counter-claims, or contribution claims,
5 which are based upon the provision of, use of, or
6 payment for (or the failure to provide, use or pay
7 for) health care services or medical products, regard-
8 less of the theory of liability on which the claim is
9 based, or the number of plaintiffs, defendants, or
10 other parties, or the number of causes of action.

11 (9) HEALTH CARE ORGANIZATION.—The term
12 “health care organization” means any person or en-
13 tity which is obligated to provide or pay for health
14 benefits under any health plan, including any person
15 or entity acting under a contract or arrangement
16 with a health care organization to provide or admin-
17 ister any health benefit.

18 (10) HEALTH CARE PROVIDER.—The term
19 “health care provider” means any person or entity
20 required by State or Federal laws or regulations to
21 be licensed, registered, or certified to provide health
22 care services, and being either so licensed, reg-
23 istered, or certified, or exempted from such require-
24 ment by other statute or regulation.

1 (11) HEALTH CARE ITEMS OR SERVICES.—The
2 term “health care items or services” means any
3 items or services provided by a health care organiza-
4 tion, provider, or by any individual working under
5 the supervision of a health care provider, that relates
6 to the diagnosis, prevention, or treatment of any
7 human disease or impairment, or the assessment or
8 care of the health of human beings.

9 (12) MALICIOUS INTENT TO INJURE.—The
10 term “malicious intent to injure” means inten-
11 tionally causing or attempting to cause physical in-
12 jury other than providing health care items or serv-
13 ices.

14 (13) MEDICAL PRODUCT.—The term “medical
15 product” means a drug, device, or biological product
16 intended for humans, and the terms “drug”, “de-
17 vice”, and “biological product” have the meanings
18 given such terms in sections 201(g)(1) and 201(h)
19 of the Federal Food, Drug, and Cosmetic Act (21
20 U.S.C. 321(g)(1) and (h)) and section 351(a) of the
21 Public Health Service Act (42 U.S.C. 262(a)), re-
22 spectively, including any component or raw material
23 used therein, but excluding health care services.

24 (14) NONECONOMIC DAMAGES.—The term
25 “noneconomic damages” means damages for phys-

1 ical impairment, mental anguish, disfigurement, loss
2 of enjoyment of life, loss of society and companion-
3 ship, loss of consortium (other than loss of domestic
4 service), hedonic damages, injury to reputation, and
5 all other nonpecuniary losses of any kind of nature.

6 (15) PATIENT SAFETY ORGANIZATION.—The
7 term “patient safety organization” has the meaning
8 given to such term in section 921 of the Public
9 Health Service Act (42 U.S.C. 299b–21).

10 (16) PUNITIVE DAMAGES.—The term “punitive
11 damages” means damages awarded, for the purpose
12 of punishment or deterrence, and not solely for com-
13 pensatory purposes, against a health care provider,
14 health care organization, or a manufacturer, dis-
15 tributor, or supplier of a medical product. Punitive
16 damages are neither economic nor economic dam-
17 ages.

18 (17) STATE.—The term “State” means each of
19 the several States, the District of Columbia, the
20 Commonwealth of Puerto Rico, the Virgin Islands,
21 Guam, American Samoa, the Northern Mariana Is-
22 lands, the Trust Territory of the Pacific Islands, and
23 any other territory or possession of the United
24 States, or any political subdivision thereof.

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