I

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.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Behavioral Health Information Technology Act of 2013''.

SEC. 2. EXTENSION OF HEALTH INFORMATION TECHNOLOGY ASSISTANCE FOR BEHAVIORAL AND MENTAL HEALTH AND SUBSTANCE ABUSE.

Section 3000(3) of the Public Health Service Act (42 U.S.C. 300jj(3)) is amended by inserting before ''and any other category'' the following: ''behavioral and mental health professionals (as defined in section 331(a)(3)(E)(i)), a substance abuse professional, a psychiatric hospital (as defined in section 1861(f) of the Social Security Act), a community mental health center meeting the criteria specified in section 1913(c), a residential or outpatient mental health or substance abuse treatment facility,''.

SEC. 3. EXTENSION OF ELIGIBILITY FOR MEDICARE AND MEDICAID HEALTH INFORMATION TECHNOLOGY IMPLEMENTATION ASSISTANCE.

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

(1) in subsection (a)(7)—

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

''(iv) ADDITIONAL ELIGIBLE PROFESSIONAL.—The term 'additional eligible professional' means a clinical psychologist providing qualified psychologist services (as defined in section 1861(ii)).''; and

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

''(F) APPLICATION TO ADDITIONAL ELIGIBLE PROFESSIONALS.—The Secretary shall apply the provisions of this paragraph with respect to an additional eligible professional in the same manner as such provisions apply to an eligible professional, except in applying subparagraph (A)—

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

''(ii) in clause (ii), the references to 2015, 2016, and 2017 shall be deemed references to 2019, 2020, and 2021, respectively; and

''(iii) in clause (iii), the reference to 2018 shall be deemed a reference to 2022.''; and

(2) in subsection (o)—

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

''(D) ADDITIONAL ELIGIBLE PROFESSIONAL.—The term 'additional eligible professional' means a clinical psychologist providing qualified psychologist services (as defined in section 1861(ii)).''; and

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

''(6) APPLICATION TO ADDITIONAL ELIGIBLE PROFESSIONALS.—The Secretary shall apply the provisions of this subsection with respect to an additional eligible professional in the same manner as such provisions apply to an eligible professional, except in applying—

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

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

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

''(D) paragraph (1)(B)(v), the references to 2014 shall be deemed references to 2018; and

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

(b) ELIGIBLE HOSPITALS.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended—

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

"(V) The Secretary shall apply the provisions of this subsection with respect to an additional eligible hospital (as defined in subsection (n)(6)(C)) in the same manner as such provisions apply to an eligible hospital, except in applying—

"(aa) subclause (I), the references to 2015, 2016, and 2017 shall be deemed references to 2019, 2020, and 2021, respectively; and

"(bb) subclause (III), the reference to 2015 shall be deemed a reference to 2019."; and

(2) in subsection (n)—

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

''(C) ADDITIONAL ELIGIBLE HOSPITAL.—The term 'additional eligible hospital' means an inpatient hospital that is a psychiatric hospital (as defined in section 1861(f)).''; and

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

''(7) APPLICATION TO ADDITIONAL ELIGIBLE HOSPITALS.—The Secretary shall apply the provisions of this subsection with respect to an additional eligible hospital in the same manner as such provisions apply to an eligible hospital, except in applying—

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

''(B) paragraph (2)(G)(i), the reference to 2011 shall be deemed a reference to 2015.''.

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

(1) in paragraph (2)(B)—

(A) in clause (i), by striking '', or'' and inserting a semicolon;

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

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

"(iii) a public hospital that is principally a psychiatric hospital (as defined in section 1861(f));

"(iv) a private hospital that is principally a psychiatric hospital (as defined in section 1861(f)) and that has at least 10 percent of its patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals receiving medical assistance under this title;

"(v) a community mental health center meeting the criteria specified in section 1913(c) of the Public Health Service Act; or

"(vi) a residential or outpatient mental health or substance abuse treatment facility that—

"(I) is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Ac-

creditation, or any other national accrediting agency recognized by the Secretary; and

''(II) has at least 10 percent of its patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals receiving medical assistance under this title.''; and

(2) in paragraph (3)(B)—

(A) in clause (iv), by striking ''and'' after the semicolon;

(B) in clause (v), by striking the period and inserting ''; and''; and

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

''(vi) clinical psychologist providing qualified psychologist services (as defined in section 1861(ii)), if such clinical psychologist is practicing in an outpatient clinic that—

''(I) is led by a clinical psychologist; and

''(II) is not otherwise receiving payment under paragraph (1) as a

Medicaid provider described in paragraph (2)(B).''.

(d) MEDICARE ADVANTAGE ORGANIZATIONS.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23) is amended—

(1) in subsection (l)—

(A) in paragraph (1)—

(i) by inserting ''or additional eligible professionals (as described in paragraph (9))'' after ''paragraph (2)''; and

(ii) by inserting ''and additional eligible professionals'' before ''under such sections'';

(B) in paragraph (3)(B)—

(i) in clause (i) in the matter preceding subclause (I), by inserting ''or an additional eligible professional described in paragraph (9)'' after ''paragraph (2)''; and

(ii) in clause (ii)—

(I) in the matter preceding subclause (I), by inserting ''or an additional eligible professional described in paragraph (9)'' after ''paragraph (2)''; and

(II) in subclause (I), by inserting ''or an additional eligible professional, respectively,'' after ''eligible professional'';

(C) in paragraph (3)(C), by inserting ''and additional eligible professionals'' after ''all eligible professionals'';

(D) in paragraph (4)(D), by adding at the end the following new sentence: ''In the case that a qualifying MA organization attests that not all additional eligible professionals of the organization are meaningful EHR users with respect to an applicable year, the Secretary shall apply the payment adjustment under this paragraph based on the proportion of all such additional eligible professionals of the organization that are not meaningful EHR users for such year.'';

(E) in paragraph (6)(A), by inserting ''and, as applicable, each additional eligible professional described in paragraph (9)'' after ''paragraph (2)'';

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

pital described in paragraph (9)'' after ''subsection (m)(1)'';

(G) in paragraph (7)(A), by inserting ''and, as applicable, additional eligible professionals'' after ''eligible professionals'';

(H) in paragraph (7)(B), by inserting ''and, as applicable, additional eligible professionals'' after ''eligible professionals'';

(I) in paragraph (8)(B), by inserting ''and additional eligible professionals described in paragraph (9)'' after ''paragraph (2)''; and

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

''(9) ADDITIONAL ELIGIBLE PROFESSIONAL DESCRIBED.—With respect to a qualifying MA organization, an additional eligible professional described in this paragraph is an additional eligible professional (as defined for purposes of section 1848(o)) who—

''(A)(i) is employed by the organization; or

''(ii)(I) is employed by, or is a partner of, an entity that through contract with the organization furnishes at least 80 percent of the entity's Medicare patient care services to enrollees of such organization; and

''(II) furnishes at least 80 percent of the professional services of the additional eligible professional covered under this title to enrollees of the organization; and

''(B) furnishes, on average, at least 20 hours per week of patient care services.''; and

(2) in subsection (m)—

(A) in paragraph (1)—

(i) by inserting ''or additional eligible hospitals (as described in paragraph (7))'' after ''paragraph (2)''; and

(ii) by inserting ''and additional eligible hospitals'' before ''under such sections'';

(B) in paragraph (3)(A)(i), by inserting ''or additional eligible hospital'' after ''eligible hospital'';

(C) in paragraph (3)(A)(ii), by inserting ''or an additional eligible hospital'' after ''eligible hospital'' in each place it occurs;

(D) in paragraph (3)(B)—

(i) in clause (i), by inserting ''or an additional eligible hospital described in paragraph (7)'' after ''paragraph (2)''; and

(ii) in clause (ii)—

(I) in the matter preceding subclause (I), by inserting ''or an additional eligible hospital described in paragraph (7)'' after ''paragraph (2)''; and

(II) in subclause (I), by inserting ''or an additional eligible hospital, respectively,'' after ''eligible hospital'';

(E) in paragraph (4)(A), by inserting ''or one or more additional eligible hospitals (as defined in section 1886(n)), as appropriate,'' after ''section 1886(n)(6)(A))'';

(F) in paragraph (4)(D), by adding at the end the following new sentence: ''In the case that a qualifying MA organization attests that not all additional eligible hospitals of the organization are meaningful EHR users with respect to an applicable period, the Secretary shall apply the payment adjustment under this paragraph based on the methodology specified by the Secretary, taking into account the proportion of such additional eligible hospitals, or discharges from such hospitals, that are not meaningful EHR users for such period.'';

(G) in paragraph (5)(A), by inserting ''and, as applicable, each additional eligible hospital described in paragraph (7)'' after ''paragraph (2)'';

(H) in paragraph (5)(B), by inserting ''and additional eligible hospitals, as applicable,'' after ''eligible hospitals'';

(I) in paragraph (6)(B), by inserting ''and additional eligible hospitals described in paragraph (7)'' after ''paragraph (2)''; and

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

''(7) ADDITIONAL ELIGIBLE HOSPITAL DESCRIBED.—With respect to a qualifying MA organization, an additional eligible hospital described in this paragraph is an additional eligible hospital (as defined in section 1886(n)(6)(C)) that is under common corporate governance with such organization and serves individuals enrolled under an MA plan offered by such organization.''.

SEC. 4. PROVIDING PROTECTIONS FOR CERTAIN PROVIDERS, VENDORS, AND USERS OF CERTIFIED EHR TECHNOLOGY.

(a) COVERED ENTITIES.—

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

(A) MEANINGFUL EHR USERS.—

(i) An eligible professional (as defined in paragraph (5)(C) of section 1848(o) of the Social Security Act (42 U.S.C. 1395w–4(o))) determined to be a meaningful EHR user under paragraph (2) of such section for the EHR reporting period (as defined in paragraph (5)(B) of such section) during such year, or an additional eligible professional (as defined in paragraph (5)(D) of such section) determined to be a meaningful EHR user pursuant to paragraph (6) of such section for the EHR reporting period (as defined in paragraph (5)(B) of such section) during such year.

(ii) In the case of a qualifying MA organization (as defined in paragraph (5) of section 1853(l) of such Act (42 U.S.C. 1395w–23(l))), an eligible professional described in paragraph (2) of such section or,

as applicable, an additional eligible professional described in paragraph (9) of such section of the organization who the organization attests under paragraph (6) of such section to be a meaningful EHR user for such year.

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

(iv) An eligible hospital (as defined in paragraph (6)(B) of section 1886(n) of such Act (42 U.S.C. 1395ww(n)) determined to be a meaningful EHR user under paragraph (3) of such section for the EHR reporting period (as defined in paragraph (6)(A) of such section) with respect to

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

(v) A critical access hospital determined pursuant to section 1814(l)(3) of such Act (42 U.S.C. 1395f(l)(3)) to be a meaningful EHR user (as would be determined under paragraph (3) of section 1886(n) of such Act (42 U.S.C. 1395ww(n))) for an EHR reporting period (as defined in paragraph (6)(A) of such section) for a cost reporting period beginning during such year.

(vi) A Medicaid provider (as defined in paragraph (2) of section 1903(t) of such Act (42 U.S.C. 1396b(t))) eligible for payments described in paragraph (1) of such section for such year.

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

ing such year are health information exchange contractors (consisting of technology providers), health information exchange participants (consisting of organizations providing supportive technology to a health information exchange), and other users of health information exchanges (consisting of other entities that may be exchanging clinical or administrative data). Manufacturers of electronic health record (EHR) software and other health information technologies who participate in the reporting of adverse events or who otherwise contribute relevant patient safety work product under subsection (b)(1).

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

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

(ii) is not eligible for incentive payments based on meaningful use of such technology under title XVIII or XIX of the Social Security Act solely because the professional is not—

(I) an eligible professional (as defined in paragraph (5)(C) of section 1848(o) of such Act (42 U.S.C. 1395w–4(o)));

(II) an eligible professional described in paragraph (2) of section 1853(l) of such Act (42 U.S.C. 1395w–23(l)) or, as applicable, an additional eligible professional described in paragraph (9) of such section, with respect to a qualifying MA organization (as defined in paragraph (5) of such section);

(III) an eligible hospital described in paragraph (2) of section 1853(m) of such Act (42 U.S.C. 1395w–23(m)) or, as applicable, an additional eligible hospital described in paragraph (7) of such section, with respect to such a qualifying MA organization;

(IV) an eligible hospital (as defined in paragraph (6)(B) of section 1886(n) of such Act (42 U.S.C. 1395ww(n)));

(V) a critical access hospital;

(VI) a Medicaid provider (as defined in paragraph (2) of section 1903(t) of such Act (42 U.S.C. 1396b(t)));

(VII) an additional eligible professional (as defined in paragraph (5)(D) of section 1848(o) of such Act (42 U.S.C. 1395w–4(o))); or

(VIII) an additional eligible hospital (as defined in paragraph (6)(C) of section 1886(n) of such Act (42 U.S.C. 1395ww(n))); and

(iii) attests, to the satisfaction of the Secretary of Health and Human Services, that but for the reason described in clause (ii), the professional would otherwise satisfy criteria to be eligible for such incentive payments during such year.

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

(1) QUARTERLY REPORTING BY PATIENT SAFETY ORGANIZATIONS.—Paragraph (1) of section 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

technology, and in the case of the collection and maintenance of such information by a patient safety organization, the provisions of section 922 of the Public Health Service Act (42 U.S.C. 299b–22) shall apply to such information and to the organization and the entity in the same manner such provisions apply to patient safety work product and a patient safety organization and provider under part C of title IX of such Act (42 U.S.C. 299b–2 et seq.).

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

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

(1) information that is related to such EHR-related adverse event; and

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

(d) LEGAL PROTECTIONS FOR COVERED ENTITIES.—

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

(A) ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.—

(i) GENERAL.—A claimant may not commence a health care lawsuit against a covered entity on any date that is 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first. This limitation shall be tolled to the extent that the claimant is able to prove—

(I) fraud;

(II) intentional concealment; or

(III) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

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

after the date of the alleged manifestation of injury except that actions by a claimant under the age of 6 years may not be commenced after the date that is 3 years after the date of manifestation of injury or prior to the claimant's 8th birthday, whichever provides a longer period. This limitation shall be tolled for claimants under the age of 17 years for any period during which a parent or guardian and a health care provider or health care organization have committed fraud or collusion in the failure to bring an action on behalf of the claimant.

(B) EQUITABLE ASSIGNMENT OF RESPONSIBILITY.—In any health care lawsuit against a covered entity—

(i) each party to the lawsuit other than the claimant that is such a covered entity shall be liable for that party's several share of any damages only and not for the share of any other person and such several share shall be in direct proportion to that party's proportion of responsibility for the injury, as determined under clause (iii);

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

(iii) for purposes of this subparagraph, the trier of fact shall determine the proportion of responsibility of each such party for the claimant's harm.

(C) SUBSEQUENT REMEDIAL MEASURES.—Evidence of subsequent remedial measures to an EHR-related adverse event with respect to certified EHR technology used or provided by the covered entity (including changes to the certified EHR system, additional training requirements, or changes to standard operating procedures) by a covered entity shall not be admissible in health care lawsuits.

(D) INCREASED BURDEN OF PROOF PROTECTION FOR COVERED ENTITIES.—Punitive damages may, if otherwise permitted by applicable State or Federal law, be awarded against any covered entity in a health care lawsuit only if it is proven by clear and convincing evidence that such entity acted with reckless disregard

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

(E) PROTECTION FROM LIBEL OR SLANDER.—Covered entities and employees, agents and representatives of covered entities are immune from civil action for libel or slander arising from information or entries made in certified EHR technology and for the transfer of such information to another eligible provider, hospital or health information exchange, if the information, transfer of information, or entries were made in good faith and without malice.

(e) DEFINITIONS.—In this section:

(1) CLAIMANT.—The term ''claimant'' means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity, or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(2) COMPENSATORY DAMAGES.—The term ''compensatory damages'' means objectively verifiable monetary losses incurred as a result of the provisions of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment in life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. Such term includes economic damages and noneconomic damages, as such terms are defined in this subsection.

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

loss of employment, and loss of business or employment opportunities.

(4) CERTIFIED EHR TECHNOLOGY.—The term ''certified EHR technology'' has the meaning given such term in section 1848(o)(4) of the Social Security Act (42 U.S.C. 1395w–4(o)(4)).

(5) EHR-RELATED ADVERSE EVENT.—The term ''EHR-related adverse event'' means, with respect to a provider, a defect, malfunction, or error in the certified health information technology or electronic health record used by the provider, or in the input or output of data maintained through such technology or record, that results or could reasonably result in harm to a patient.

(6) HEALTH CARE LAWSUIT.—The term ''health care lawsuit'' means any health care liability claim concerning the provision of health care items or services or any medical product affecting interstate commerce, or any health care liability action concerning the provision of health care items or services or any medical product affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier,

marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim. Such term does not include a claim or action which is based on criminal liability; which seeks civil fines or penalties paid to Federal, State, or local government; or which is grounded in antitrust.

(7) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(8) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a demand by any person, whether or not pursuant to alternative dispute resolution, against a health care pro-

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

(9) HEALTH CARE ORGANIZATION.—The term ''health care organization'' means any person or entity which is obligated to provide or pay for health benefits under any health plan, including any person or entity acting under a contract or arrangement with a health care organization to provide or administer any health benefit.

(10) HEALTH CARE PROVIDER.—The term ''health care provider'' means any person or entity required by State or Federal laws or regulations to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(11) HEALTH CARE ITEMS OR SERVICES.—The term ''health care items or services'' means any items or services provided by a health care organization, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, or treatment of any human disease or impairment, or the assessment or care of the health of human beings.

(12) MALICIOUS INTENT TO INJURE.—The term ''malicious intent to injure'' means intentionally causing or attempting to cause physical injury other than providing health care items or services.

(13) MEDICAL PRODUCT.—The term ''medical product'' means a drug, device, or biological product intended for humans, and the terms ''drug'', ''device'', and ''biological product'' have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1) and (h)) and section 351(a) of the Public Health Service Act (42 U.S.C. 262(a)), respectively, including any component or raw material used therein, but excluding health care services.

(14) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages for phys-

ical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind of nature.

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

(16) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider, health care organization, or a manufacturer, distributor, or supplier of a medical product. Punitive damages are neither economic nor economic damages.

(17) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

○