

109TH CONGRESS
1ST SESSION

H. R. 4642

To enhance the adoption of a nationwide interoperable health information technology system and to improve the quality and reduce the costs of health care in the United States.

IN THE HOUSE OF REPRESENTATIVES

DECEMBER 18, 2005

Mr. ISSA introduced the following bill; which was referred to the Committee on Energy and Commerce

A BILL

To enhance the adoption of a nationwide interoperable health information technology system and to improve the quality and reduce the costs of health care in the United States.

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Wired for Health Care
5 Quality Act”.

6 **SEC. 2. IMPROVING HEALTH CARE, QUALITY, SAFETY, AND**
7 **EFFICIENCY.**

8 The Public Health Service Act (42 U.S.C. 201 et
9 seq.) is amended by adding at the end the following:

1 **“TITLE XXIX—HEALTH**
2 **INFORMATION TECHNOLOGY**

3 **“SEC. 2901. DEFINITIONS.**

4 “In this title:

5 “(1) HEALTH CARE PROVIDER.—The term
6 ‘health care provider’ means a hospital, skilled nurs-
7 ing facility, home health entity, health care clinic,
8 federally qualified health center, group practice (as
9 defined in section 1877(h)(4) of the Social Security
10 Act), a pharmacist, a pharmacy, a laboratory, a phy-
11 sician (as defined in section 1861(r) of the Social
12 Security Act), a health facility operated by or pursu-
13 ant to a contract with the Indian Health Service, a
14 rural health clinic, and any other category of facility
15 or clinician determined appropriate by the Secretary.

16 “(2) HEALTH INFORMATION.—The term ‘health
17 information’ has the meaning given such term in
18 section 1171(4) of the Social Security Act.

19 “(3) HEALTH INSURANCE PLAN.—The term
20 ‘health insurance plan’ means—

21 “(A) a health insurance issuer (as defined
22 in section 2791(b)(2));

23 “(B) a group health plan (as defined in
24 section 2791(a)(1)); and

1 “(C) a health maintenance organization
2 (as defined in section 2791(b)(3)).

3 “(4) LABORATORY.—The term ‘laboratory’ has
4 the meaning given that term in section 353.

5 “(5) PHARMACIST.—The term ‘pharmacist’ has
6 the meaning given that term in section 804 of the
7 Federal Food, Drug, and Cosmetic Act.

8 “(6) QUALIFIED HEALTH INFORMATION TECH-
9 NOLOGY.—The term ‘qualified health information
10 technology’ means a computerized system (including
11 hardware, software, and training) that—

12 “(A) protects the privacy and security of
13 health information;

14 “(B) maintains and provides permitted ac-
15 cess to health information in an electronic for-
16 mat;

17 “(C) incorporates decision support to re-
18 duce medical errors and enhance health care
19 quality;

20 “(D) complies with the standards adopted
21 by the Federal Government under section 2903;
22 and

23 “(E) allows for the reporting of quality
24 measures under section 2908.

1 “(7) STATE.—The term ‘State’ means each of
2 the several States, the District of Columbia, Puerto
3 Rico, the Virgin Islands, Guam, American Samoa,
4 and the Northern Mariana Islands.

5 **“SEC. 2902. OFFICE OF THE NATIONAL COORDINATOR OF**
6 **HEALTH INFORMATION TECHNOLOGY.**

7 “(a) OFFICE OF NATIONAL HEALTH INFORMATION
8 TECHNOLOGY.—There is established within the Office of
9 the Secretary an Office of the National Coordinator of
10 Health Information Technology (referred to in this section
11 as the ‘Office’). The Office shall be headed by a National
12 Coordinator who shall be appointed by the President, in
13 consultation with the Secretary, and shall report directly
14 to the Secretary.

15 “(b) PURPOSE.—It shall be the purpose of the Office
16 to carry out programs and activities to develop a nation-
17 wide interoperable health information technology infra-
18 structure that—

19 “(1) ensures that patients’ health information
20 is secure and protected;

21 “(2) improves health care quality, reduces med-
22 ical errors, and advances the delivery of patient-cen-
23 tered medical care;

1 “(3) reduces health care costs resulting from
2 inefficiency, medical errors, inappropriate care, and
3 incomplete information;

4 “(4) ensures that appropriate information to
5 help guide medical decisions is available at the time
6 and place of care;

7 “(5) promotes a more effective marketplace,
8 greater competition, and increased choice through
9 the wider availability of accurate information on
10 health care costs, quality, and outcomes;

11 “(6) improves the coordination of care and in-
12 formation among hospitals, laboratories, physician
13 offices, and other entities through an effective infra-
14 structure for the secure and authorized exchange of
15 health care information;

16 “(7) improves public health reporting and facili-
17 tates the early identification and rapid response to
18 public health threats and emergencies, including bio-
19 terror events and infectious disease outbreaks;

20 “(8) facilitates health research; and

21 “(9) promotes prevention of chronic diseases.

22 “(c) DUTIES OF THE NATIONAL COORDINATOR.—

23 The National Coordinator shall—

1 “(1) serve as a member of the public-private
2 American Health Information Collaborative estab-
3 lished under section 2903;

4 “(2) serve as the principal advisor to the Sec-
5 retary concerning the development, application, and
6 use of health information technology, and coordinate
7 and oversee the health information technology pro-
8 grams of the Department;

9 “(3) facilitate the adoption of a nationwide,
10 interoperable system for the electronic exchange of
11 health information;

12 “(4) ensure the adoption and implementation of
13 standards for the electronic exchange of health infor-
14 mation to reduce cost and improve health care qual-
15 ity;

16 “(5) ensure that health information technology
17 policy and programs of the Department are coordi-
18 nated with those of relevant executive branch agen-
19 cies (including Federal commissions) with a goal of
20 avoiding duplication of efforts and of helping to en-
21 sure that each agency undertakes health information
22 technology activities primarily within the areas of its
23 greatest expertise and technical capability;

24 “(6) to the extent permitted by law, coordinate
25 outreach and consultation by the relevant executive

1 branch agencies (including Federal commissions)
2 with public and private parties of interest, including
3 consumers, payers, employers, hospitals and other
4 health care providers, physicians, community health
5 centers, laboratories, vendors and other stake-
6 holders;

7 “(7) advise the President regarding specific
8 Federal health information technology programs;
9 and

10 “(8) submit the reports described under section
11 2903(i) (excluding paragraph (4) of such section).

12 “(d) DETAIL OF FEDERAL EMPLOYEES.—

13 “(1) IN GENERAL.—Upon the request of the
14 National Coordinator, the head of any Federal agen-
15 cy is authorized to detail, with or without reimburse-
16 ment from the Office, any of the personnel of such
17 agency to the Office to assist it in carrying out its
18 duties under this section.

19 “(2) EFFECT OF DETAIL.—Any detail of per-
20 sonnel under paragraph (1) shall—

21 “(A) not interrupt or otherwise affect the
22 civil service status or privileges of the Federal
23 employee; and

1 “(2) serve as a forum for the participation of
2 a broad range of stakeholders to provide input on
3 achieving the interoperability of health information
4 technology; and

5 “(3) recommend standards (including content,
6 communication, and security standards) for the elec-
7 tronic exchange of health information for adoption
8 by the Federal Government and voluntary adoption
9 by private entities.

10 “(b) COMPOSITION.—

11 “(1) IN GENERAL.—The Collaborative shall be
12 composed of—

13 “(A) the Secretary, who shall serve as the
14 chairperson of the Collaborative;

15 “(B) the Secretary of Defense, or his or
16 her designee;

17 “(C) the Secretary of Veterans Affairs, or
18 his or her designee;

19 “(D) the Secretary of Commerce, or his or
20 her designee;

21 “(E) the National Coordinator for Health
22 Information Technology;

23 “(F) representatives of other relevant Fed-
24 eral agencies, as determined appropriate by the
25 Secretary; and

1 “(G) representatives from each of the fol-
2 lowing categories to be appointed by the Sec-
3 retary from nominations submitted by the pub-
4 lic—

5 “(i) consumer and patient organiza-
6 tions;

7 “(ii) experts in health information pri-
8 vacy and security;

9 “(iii) health care providers;

10 “(iv) health insurance plans or other
11 third party payors;

12 “(v) standards development organiza-
13 tions;

14 “(vi) information technology vendors;

15 “(vii) purchasers or employers; and

16 “(viii) State or local government agen-
17 cies or Indian tribe or tribal organizations.

18 “(2) CONSIDERATIONS.—In appointing mem-
19 bers under paragraph (1)(G), the Secretary shall se-
20 lect individuals with expertise in—

21 “(A) health information privacy;

22 “(B) health information security;

23 “(C) health care quality and patient safety,
24 including those individuals with experience in

1 utilizing health information technology to im-
2 prove health care quality and patient safety;

3 “(D) data exchange; and

4 “(E) developing health information tech-
5 nology standards and new health information
6 technology.

7 “(3) TERMS.—Members appointed under para-
8 graph (1)(G) shall serve for 2 year terms, except
9 that any member appointed to fill a vacancy for an
10 unexpired term shall be appointed for the remainder
11 of such term. A member may serve for not to exceed
12 180 days after the expiration of such member’s term
13 or until a successor has been appointed.

14 “(c) RECOMMENDATIONS AND POLICIES.—The Col-
15 laborative shall make recommendations to identify uni-
16 form national policies for adoption by the Federal Govern-
17 ment and voluntary adoption by private entities to support
18 the widespread adoption of health information technology,
19 including—

20 “(1) protection of health information through
21 privacy and security practices;

22 “(2) measures to prevent unauthorized access
23 to health information;

24 “(3) methods to facilitate secure patient access
25 to health information;

1 “(4) the ongoing harmonization of industry-
2 wide health information technology standards;

3 “(5) recommendations for a nationwide inter-
4 operable health information technology infrastruc-
5 ture;

6 “(6) the identification and prioritization of spe-
7 cific use cases for which health information tech-
8 nology is valuable, beneficial, and feasible;

9 “(7) recommendations for the establishment of
10 an entity to ensure the continuation of the functions
11 of the Collaborative; and

12 “(8) other policies determined to be necessary
13 by the Collaborative.

14 “(d) STANDARDS.—

15 “(1) EXISTING STANDARDS.—The standards
16 adopted by the Consolidated Health Informatics Ini-
17 tiative shall be deemed to have been recommended
18 by the Collaborative under this section.

19 “(2) FIRST YEAR REVIEW.—Not later than 1
20 year after the date of enactment of this title, the
21 Collaborative shall—

22 “(A) review existing standards (including
23 content, communication, and security stand-
24 ards) for the electronic exchange of health in-

1 formation, including such standards adopted by
2 the Secretary under paragraph (2)(A);

3 “(B) identify deficiencies and omissions in
4 such existing standards; and

5 “(C) identify duplication and overlap in
6 such existing standards;

7 and recommend modifications to such standards as
8 necessary.

9 “(3) ONGOING REVIEW.—Beginning 1 year
10 after the date of enactment of this title, and annu-
11 ally thereafter, the Collaborative shall—

12 “(A) review existing standards (including
13 content, communication, and security stand-
14 ards) for the electronic exchange of health in-
15 formation, including such standards adopted by
16 the Secretary under paragraph (2)(A);

17 “(B) identify deficiencies and omissions in
18 such existing standards; and

19 “(C) identify duplication and overlap in
20 such existing standards;

21 and recommend modifications to such standards as
22 necessary.

23 “(4) LIMITATION.—The standards described in
24 this section shall be consistent with any standards

1 developed pursuant to the Health Insurance Port-
2 ability and Accountability Act of 1996.

3 “(e) FEDERAL ACTION.—Not later than 60 days
4 after the issuance of a recommendation from the Collabo-
5 rative under subsection (d)(2), the Secretary of Health
6 and Human Services, the Secretary of Veterans Affairs,
7 and the Secretary of Defense, in collaboration with rep-
8 resentatives of other relevant Federal agencies, as deter-
9 mined appropriate by the Secretary, shall jointly review
10 such recommendations. The Secretary shall provide for the
11 adoption by the Federal Government of any standard or
12 standards contained in such recommendation.

13 “(f) COORDINATION OF FEDERAL SPENDING.—Not
14 later than 1 year after the adoption by the Federal Gov-
15 ernment of a recommendation as provided for in sub-
16 section (e), and in compliance with chapter 113 of title
17 40, United States Code, no Federal agency shall expend
18 Federal funds for the purchase of any form of health in-
19 formation technology or health information technology
20 system for clinical care or for the electronic retrieval, stor-
21 age, or exchange of health information that is not con-
22 sistent with applicable standards adopted by the Federal
23 Government under subsection (e).

24 “(g) COORDINATION OF FEDERAL DATA COLLEC-
25 TION.—Not later than 3 years after the adoption by the

1 Federal Government of a recommendation as provided for
2 in subsection (e), all Federal agencies collecting health
3 data for the purposes of surveillance, epidemiology, ad-
4 verse event reporting, research, or for other purposes de-
5 termined appropriate by the Secretary shall comply with
6 standards adopted under subsection (e).

7 “(h) VOLUNTARY ADOPTION.—Any standards adopt-
8 ed by the Federal Government under subsection (e) shall
9 be voluntary with respect to private entities.

10 “(i) REPORTS.—The Secretary shall submit to the
11 Committee on Health, Education, Labor, and Pensions
12 and the Committee on Finance of the Senate and the
13 Committee on Energy and Commerce and the Committee
14 on Ways and Means of the House of Representatives, on
15 an annual basis, a report that—

16 “(1) describes the specific actions that have
17 been taken by the Federal Government and private
18 entities to facilitate the adoption of an interoperable
19 nationwide system for the electronic exchange of
20 health information;

21 “(2) describes barriers to the adoption of such
22 a nationwide system;

23 “(3) contains recommendations to achieve full
24 implementation of such a nationwide system; and

1 private entities in technical conformance with such
2 standards adopted under this title.

3 “(2) IMPLEMENTATION ASSISTANCE.—The Sec-
4 retary may recognize a private entity or entities to
5 assist private entities in the implementation of the
6 standards adopted under this title using the criteria
7 developed by the Secretary under this section.

8 “(b) CERTIFICATION.—

9 “(1) IN GENERAL.—The Secretary, based upon
10 the recommendations of the Collaborative, shall de-
11 velop criteria to ensure and certify that hardware,
12 software, and support services that claim to be in
13 compliance with any standard for the electronic ex-
14 change of health information adopted under this title
15 have established and maintained such compliance in
16 technical conformance with such standards.

17 “(2) CERTIFICATION ASSISTANCE.—The Sec-
18 retary may recognize a private entity or entities to
19 assist in the certification described under paragraph
20 (1) using the criteria developed by the Secretary
21 under this section.

22 “(c) DELEGATION AUTHORITY.—The Secretary,
23 through consultation with the Collaborative, may delegate
24 the development of the criteria under subsections (a) and
25 (b) to a private entity.

1 **“SEC. 2905. GRANTS TO FACILITATE THE WIDESPREAD**
2 **ADOPTION OF INTEROPERABLE HEALTH IN-**
3 **FORMATION TECHNOLOGY.**

4 “(a) COMPETITIVE GRANTS TO FACILITATE THE
5 WIDESPREAD ADOPTION OF HEALTH INFORMATION
6 TECHNOLOGY.—

7 “(1) IN GENERAL.—The Secretary may award
8 competitive grants to eligible entities to facilitate the
9 purchase and enhance the utilization of qualified
10 health information technology systems to improve
11 the quality and efficiency of health care.

12 “(2) ELIGIBILITY.—To be eligible to receive a
13 grant under paragraph (1) an entity shall—

14 “(A) submit to the Secretary an applica-
15 tion at such time, in such manner, and con-
16 taining such information as the Secretary may
17 require;

18 “(B) submit to the Secretary a strategic
19 plan for the implementation of data sharing
20 and interoperability measures;

21 “(C) be a—

22 “(i) not for profit hospital;

23 “(ii) group practice (including a single
24 physician); or

25 “(iii) another health care provider not
26 described in clause (i) or (ii);

1 “(D) adopt the standards adopted by the
2 Federal Government under section 2903;

3 “(E) require that health care providers re-
4 ceiving such grants implement the measurement
5 system adopted under section 2908 and report
6 to the Secretary on such measures;

7 “(F) demonstrate significant financial
8 need; and

9 “(G) provide matching funds in accordance
10 with paragraph (4).

11 “(3) USE OF FUNDS.—Amounts received under
12 a grant under this subsection shall be used to facili-
13 tate the purchase and enhance the utilization of
14 qualified health information technology systems.

15 “(4) MATCHING REQUIREMENT.—To be eligible
16 for a grant under this subsection an entity shall con-
17 tribute non-Federal contributions to the costs of car-
18 rying out the activities for which the grant is award-
19 ed in an amount equal to \$1 for each \$3 of Federal
20 funds provided under the grant.

21 “(5) PREFERENCE IN AWARDING GRANTS.—In
22 awarding grants under this subsection the Secretary
23 shall give preference to—

1 “(A) eligible entities that are located in
2 rural, frontier, and other underserved areas as
3 determined by the Secretary; and

4 “(B) eligible entities that will link, to the
5 extent practicable, the qualified health informa-
6 tion system to local or regional health informa-
7 tion networks.

8 “(b) COMPETITIVE GRANTS TO STATES FOR THE DE-
9 VELOPMENT OF STATE LOAN PROGRAMS TO FACILITATE
10 THE WIDESPREAD ADOPTION OF HEALTH INFORMATION
11 TECHNOLOGY.—

12 “(1) IN GENERAL.—The Secretary may award
13 competitive grants to States for the establishment of
14 State programs for loans to health care providers to
15 facilitate the purchase and enhance the utilization of
16 qualified health information technology.

17 “(2) ESTABLISHMENT OF FUND.—To be eligi-
18 ble to receive a competitive grant under this sub-
19 section, a State shall establish a qualified health in-
20 formation technology loan fund (referred to in this
21 subsection as a ‘State loan fund’) and comply with
22 the other requirements contained in this section. A
23 grant to a State under this subsection shall be de-
24 posited in the State loan fund established by the
25 State. No funds authorized by other provisions of

1 this title to be used for other purposes specified in
2 this title shall be deposited in any State loan fund.

3 “(3) ELIGIBILITY.—To be eligible to receive a
4 grant under paragraph (1) a State shall—

5 “(A) submit to the Secretary an applica-
6 tion at such time, in such manner, and con-
7 taining such information as the Secretary may
8 require;

9 “(B) submit to the Secretary a strategic
10 plan in accordance with paragraph (4);

11 “(C) establish a qualified health informa-
12 tion technology loan fund in accordance with
13 paragraph (2);

14 “(D) require that health care providers re-
15 ceiving such loans—

16 “(i) link, to the extent practicable, the
17 qualified health information system to a
18 local or regional health information net-
19 work; and

20 “(ii) consult with the Center for Best
21 Practices established in section 914(d) to
22 access the knowledge and experience of ex-
23 isting initiatives regarding the successful
24 implementation and effective use of health
25 information technology;

1 “(E) require that health care providers re-
2 ceiving such loans adopt the standards adopted
3 by the Federal Government under section
4 2903(d);

5 “(F) require that health care providers re-
6 ceiving such loans implement the measurement
7 system adopted under section 2908 and report
8 to the Secretary on such measures; and

9 “(G) provide matching funds in accordance
10 with paragraph (8).

11 “(4) STRATEGIC PLAN.—

12 “(A) IN GENERAL.—A State that receives
13 a grant under this subsection shall annually
14 prepare a strategic plan that identifies the in-
15 tended uses of amounts available to the State
16 loan fund of the State.

17 “(B) CONTENTS.—A strategic plan under
18 subparagraph (A) shall include—

19 “(i) a list of the projects to be as-
20 sisted through the State loan fund in the
21 first fiscal year that begins after the date
22 on which the plan is submitted;

23 “(ii) a description of the criteria and
24 methods established for the distribution of
25 funds from the State loan fund; and

1 “(iii) a description of the financial
2 status of the State loan fund and the
3 short-term and long-term goals of the
4 State loan fund.

5 “(5) USE OF FUNDS.—

6 “(A) IN GENERAL.—Amounts deposited in
7 a State loan fund, including loan repayments
8 and interest earned on such amounts, shall be
9 used only for awarding loans or loan guaran-
10 tees, or as a source of reserve and security for
11 leveraged loans, the proceeds of which are de-
12 posited in the State loan fund established under
13 paragraph (1). Loans under this section may be
14 used by a health care provider to facilitate the
15 purchase and enhance the utilization of quali-
16 fied health information technology.

17 “(B) LIMITATION.—Amounts received by a
18 State under this subsection may not be used—

19 “(i) for the purchase or other acquisi-
20 tion of any health information technology
21 system that is not a qualified health infor-
22 mation technology system;

23 “(ii) to conduct activities for which
24 Federal funds are expended under this

1 title, or the amendments made by the
2 Wired for Health Care Quality Act; or

3 “(iii) for any purpose other than mak-
4 ing loans to eligible entities under this sec-
5 tion.

6 “(6) TYPES OF ASSISTANCE.—Except as other-
7 wise limited by applicable State law, amounts depos-
8 ited into a State loan fund under this subsection
9 may only be used for the following:

10 “(A) To award loans that comply with the
11 following:

12 “(i) The interest rate for each loan
13 shall be less than or equal to the market
14 interest rate.

15 “(ii) The principal and interest pay-
16 ments on each loan shall commence not
17 later than 1 year after the loan was award-
18 ed, and each loan shall be fully amortized
19 not later than 10 years after the date of
20 the loan.

21 “(iii) The State loan fund shall be
22 credited with all payments of principal and
23 interest on each loan awarded from the
24 fund.

1 “(B) To guarantee, or purchase insurance
2 for, a local obligation (all of the proceeds of
3 which finance a project eligible for assistance
4 under this subsection) if the guarantee or pur-
5 chase would improve credit market access or re-
6 duce the interest rate applicable to the obliga-
7 tion involved.

8 “(C) As a source of revenue or security for
9 the payment of principal and interest on rev-
10 enue or general obligation bonds issued by the
11 State if the proceeds of the sale of the bonds
12 will be deposited into the State loan fund.

13 “(D) To earn interest on the amounts de-
14 posited into the State loan fund.

15 “(7) ADMINISTRATION OF STATE LOAN
16 FUNDS.—

17 “(A) COMBINED FINANCIAL ADMINISTRA-
18 TION.—A State may (as a convenience and to
19 avoid unnecessary administrative costs) com-
20 bine, in accordance with State law, the financial
21 administration of a State loan fund established
22 under this subsection with the financial admin-
23 istration of any other revolving fund established
24 by the State if otherwise not prohibited by the

1 law under which the State loan fund was estab-
2 lished.

3 “(B) COST OF ADMINISTERING FUND.—
4 Each State may annually use not to exceed 4
5 percent of the funds provided to the State
6 under a grant under this subsection to pay the
7 reasonable costs of the administration of the
8 programs under this section, including the re-
9 covery of reasonable costs expended to establish
10 a State loan fund which are incurred after the
11 date of enactment of this title.

12 “(C) GUIDANCE AND REGULATIONS.—The
13 Secretary shall publish guidance and promul-
14 gate regulations as may be necessary to carry
15 out the provisions of this subsection, includ-
16 ing—

17 “(i) provisions to ensure that each
18 State commits and expends funds allotted
19 to the State under this subsection as effi-
20 ciently as possible in accordance with this
21 title and applicable State laws; and

22 “(ii) guidance to prevent waste, fraud,
23 and abuse.

24 “(D) PRIVATE SECTOR CONTRIBUTIONS.—

1 “(i) IN GENERAL.—A State loan fund
2 established under this subsection may ac-
3 cept contributions from private sector enti-
4 ties, except that such entities may not
5 specify the recipient or recipients of any
6 loan issued under this subsection.

7 “(ii) AVAILABILITY OF INFORMA-
8 TION.—A State shall make publically avail-
9 able the identity of, and amount contrib-
10 uted by, any private sector entity under
11 clause (i) and may issue letters of com-
12 mendation or make other awards (that
13 have no financial value) to any such entity.

14 “(8) MATCHING REQUIREMENTS.—

15 “(A) IN GENERAL.—The Secretary may
16 not make a grant under paragraph (1) to a
17 State unless the State agrees to make available
18 (directly or through donations from public or
19 private entities) non-Federal contributions in
20 cash toward the costs of the State program to
21 be implemented under the grant in an amount
22 equal to not less than \$1 for each \$1 of Federal
23 funds provided under the grant.

24 “(B) DETERMINATION OF AMOUNT OF
25 NON-FEDERAL CONTRIBUTION.—In determining

1 the amount of non-Federal contributions that a
2 State has provided pursuant to subparagraph
3 (A), the Secretary may not include any
4 amounts provided to the State by the Federal
5 Government.

6 “(9) PREFERENCE IN AWARDING GRANTS.—
7 The Secretary may give a preference in awarding
8 grants under this subsection to States that adopt
9 value-based purchasing programs to improve health
10 care quality.

11 “(10) REPORTS.—The Secretary shall annually
12 submit to the Committee on Health, Education,
13 Labor, and Pensions and the Committee on Finance
14 of the Senate, and the Committee on Energy and
15 Commerce and the Committee on Ways and Means
16 of the House of Representatives, a report summa-
17 rizing the reports received by the Secretary from
18 each State that receives a grant under this sub-
19 section.

20 “(c) GRANTS FOR THE IMPLEMENTATION OF RE-
21 GIONAL OR LOCAL HEALTH INFORMATION TECHNOLOGY
22 PLANS.—

23 “(1) IN GENERAL.—The Secretary may award
24 competitive grants to eligible entities to implement
25 regional or local health information plans to improve

1 health care quality and efficiency through the elec-
2 tronic exchange of health information pursuant to
3 the standards, protocols, and other requirements
4 adopted by the Secretary under sections 2903 and
5 2908.

6 “(2) ELIGIBILITY.—To be eligible to receive a
7 grant under paragraph (1) an entity shall—

8 “(A) demonstrate financial need to the
9 Secretary;

10 “(B) demonstrate that one of its principal
11 missions or purposes is to use information tech-
12 nology to improve health care quality and effi-
13 ciency;

14 “(C) adopt bylaws, memoranda of under-
15 standing, or other charter documents that dem-
16 onstrate that the governance structure and de-
17 cisionmaking processes of such entity allow for
18 participation on an ongoing basis by multiple
19 stakeholders within a community, including—

20 “(i) physicians (as defined in section
21 1861(r) of the Social Security Act), includ-
22 ing physicians that provide services to low
23 income and underserved populations;

- 1 “(ii) hospitals (including hospitals
2 that provide services to low income and un-
3 derserved populations);
- 4 “(iii) pharmacists or pharmacies;
- 5 “(iv) health insurance plans;
- 6 “(v) health centers (as defined in sec-
7 tion 330(b)) and Federally qualified health
8 centers (as defined in section 1861(aa)(4)
9 of the Social Security Act);
- 10 “(vi) rural health clinics (as defined in
11 section 1861(aa) of the Social Security
12 Act);
- 13 “(vii) patient or consumer organiza-
14 tions;
- 15 “(viii) employers; and
- 16 “(ix) any other health care providers
17 or other entities, as determined appro-
18 priate by the Secretary;
- 19 “(D) adopt nondiscrimination and conflict
20 of interest policies that demonstrate a commit-
21 ment to open, fair, and nondiscriminatory par-
22 ticipation in the health information plan by all
23 stakeholders;
- 24 “(E) adopt the standards adopted by the
25 Secretary under section 2903;

1 “(F) require that health care providers re-
2 ceiving such loans implement the measurement
3 system adopted under section 2908 and report
4 to the Secretary on such measures;

5 “(G) facilitate the electronic exchange of
6 health information within the local or regional
7 area and among local and regional areas;

8 “(H) prepare and submit to the Secretary
9 an application in accordance with paragraph
10 (3); and

11 “(I) agree to provide matching funds in ac-
12 cordance with paragraph (5).

13 “(3) APPLICATION.—

14 “(A) IN GENERAL.—To be eligible to re-
15 ceive a grant under paragraph (1), an entity
16 shall submit to the Secretary an application at
17 such time, in such manner, and containing such
18 information as the Secretary may require.

19 “(B) REQUIRED INFORMATION.—At a
20 minimum, an application submitted under this
21 paragraph shall include—

22 “(i) clearly identified short-term and
23 long-term objectives of the regional or local
24 health information plan;

1 “(ii) a technology plan that complies
2 with the standards adopted under section
3 2903 and that includes a descriptive and
4 reasoned estimate of costs of the hardware,
5 software, training, and consulting services
6 necessary to implement the regional or
7 local health information plan;

8 “(iii) a strategy that includes initia-
9 tives to improve health care quality and ef-
10 ficiency, including the use and reporting of
11 health care quality measures adopted
12 under section 2908;

13 “(iv) a plan that describes provisions
14 to encourage the implementation of the
15 electronic exchange of health information
16 by all physicians, including single physician
17 practices and small physician groups par-
18 ticipating in the health information plan;

19 “(v) a plan to ensure the privacy and
20 security of personal health information
21 that is consistent with Federal and State
22 law;

23 “(vi) a governance plan that defines
24 the manner in which the stakeholders shall

1 jointly make policy and operational deci-
2 sions on an ongoing basis; and

3 “(vii) a financial or business plan that
4 describes—

5 “(I) the sustainability of the
6 plan;

7 “(II) the financial costs and ben-
8 efits of the plan; and

9 “(III) the entities to which such
10 costs and benefits will accrue.

11 “(4) USE OF FUNDS.—Amounts received under
12 a grant under paragraph (1) shall be used to estab-
13 lish and implement a regional or local health infor-
14 mation plan in accordance with this subsection.

15 “(5) MATCHING REQUIREMENT.—

16 “(A) IN GENERAL.—The Secretary may
17 not make a grant under this subsection to an
18 entity unless the entity agrees that, with re-
19 spect to the costs to be incurred by the entity
20 in carrying out the infrastructure program for
21 which the grant was awarded, the entity will
22 make available (directly or through donations
23 from public or private entities) non-Federal
24 contributions toward such costs in an amount
25 equal to not less than 50 percent of such costs

1 (\$1 for each \$2 of Federal funds provided
2 under the grant).

3 “(B) DETERMINATION OF AMOUNT CON-
4 TRIBUTED.—Non-Federal contributions re-
5 quired under subparagraph (A) may be in cash
6 or in kind, fairly evaluated, including equip-
7 ment, technology, or services. Amounts provided
8 by the Federal Government, or services assisted
9 or subsidized to any significant extent by the
10 Federal Government, may not be included in
11 determining the amount of such non-Federal
12 contributions.

13 “(d) REPORTS.—Not later than 1 year after the date
14 on which the first grant is awarded under this section,
15 and annually thereafter during the grant period, an entity
16 that receives a grant under this section shall submit to
17 the Secretary a report on the activities carried out under
18 the grant involved. Each such report shall include—

19 “(1) a description of the financial costs and
20 benefits of the project involved and of the entities to
21 which such costs and benefits accrue;

22 “(2) an analysis of the impact of the project on
23 health care quality and safety;

1 “(3) a description of any reduction in duplica-
2 tive or unnecessary care as a result of the project in-
3 volved;

4 “(4) a description of the efforts of recipients
5 under this section to facilitate secure patient access
6 to health information; and

7 “(5) other information as required by the Sec-
8 retary.

9 “(e) AUTHORIZATION OF APPROPRIATIONS.—

10 “(1) IN GENERAL.—For the purpose of car-
11 rying out this section, there is authorized to be ap-
12 propriated \$125,000,000 for fiscal year 2006,
13 \$150,000,000 for fiscal year 2007, and such sums
14 as may be necessary for each of fiscal years 2008
15 through 2010.

16 “(2) AVAILABILITY.—Amounts appropriated
17 under paragraph (1) shall remain available through
18 fiscal year 2010.

19 **“SEC. 2906. DEMONSTRATION PROGRAM TO INTEGRATE IN-**
20 **FORMATION TECHNOLOGY INTO CLINICAL**
21 **EDUCATION.**

22 “(a) IN GENERAL.—The Secretary may award grants
23 under this section to carry out demonstration projects to
24 develop academic curricula integrating qualified health in-
25 formation technology systems in the clinical education of

1 health professionals. Such awards shall be made on a com-
2 petitive basis and pursuant to peer review.

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

5 “(1) submit to the Secretary an application at
6 such time, in such manner, and containing such in-
7 formation as the Secretary may require;

8 “(2) submit to the Secretary a strategic plan
9 for integrating qualified health information tech-
10 nology in the clinical education of health profes-
11 sionals and for ensuring the consistent utilization of
12 decision support software to reduce medical errors
13 and enhance health care quality;

14 “(3) be—

15 “(A) a health professions school;

16 “(B) a school of nursing; or

17 “(C) a graduate medical education pro-
18 gram;

19 “(4) provide for the collection of data regarding
20 the effectiveness of the demonstration project to be
21 funded under the grant in improving the safety of
22 patients, the efficiency of health care delivery, and
23 in increasing the likelihood that graduates of the
24 grantee will adopt and incorporate health informa-

1 tion technology in the delivery of health care serv-
2 ices; and

3 “(5) provide matching funds in accordance with
4 subsection (c).

5 “(c) USE OF FUNDS.—

6 “(1) IN GENERAL.—With respect to a grant
7 under subsection (a), an eligible entity shall—

8 “(A) use grant funds in collaboration with
9 2 or more disciplines; and

10 “(B) use grant funds to integrate qualified
11 health information technology into community-
12 based clinical education.

13 “(2) LIMITATION.—An eligible entity shall not
14 use amounts received under a grant under sub-
15 section (a) to purchase hardware, software, or serv-
16 ices.

17 “(d) MATCHING FUNDS.—

18 “(1) IN GENERAL.—The Secretary may award
19 a grant to an entity under this section only if the
20 entity agrees to make available non-Federal con-
21 tributions toward the costs of the program to be
22 funded under the grant in an amount that is not
23 less than \$1 for each \$2 of Federal funds provided
24 under the grant.

1 “(2) DETERMINATION OF AMOUNT CONTRIB-
2 UTED.—Non-Federal contributions under paragraph
3 (1) may be in cash or in kind, fairly evaluated, in-
4 cluding equipment or services. Amounts provided by
5 the Federal Government, or services assisted or sub-
6 sidized to any significant extent by the Federal Gov-
7 ernment, may not be included in determining the
8 amount of such contributions.

9 “(e) EVALUATION.—The Secretary shall take such
10 action as may be necessary to evaluate the projects funded
11 under this section and publish, make available, and dis-
12 seminate the results of such evaluations on as wide a basis
13 as is practicable.

14 “(f) REPORTS.—Not later than 1 year after the date
15 of enactment of this title, and annually thereafter, the Sec-
16 retary shall submit to the Committee on Health, Edu-
17 cation, Labor, and Pensions and the Committee on Fi-
18 nance of the Senate, and the Committee on Energy and
19 Commerce and the Committee on Ways and Means of the
20 House of Representatives a report that—

21 “(1) describes the specific projects established
22 under this section; and

23 “(2) contains recommendations for Congress
24 based on the evaluation conducted under subsection
25 (e).

1 “(2) makes recommendations to States regard-
2 ing the harmonization of State laws based on the re-
3 sults of such study.

4 **“SEC. 2908. QUALITY MEASUREMENT SYSTEMS.**

5 “(a) IN GENERAL.—The Secretary of Health and
6 Human Services, the Secretary of Veterans Affairs, the
7 Secretary of Defense, and representatives of other relevant
8 Federal agencies, as determined appropriate by the Sec-
9 retary, (referred to in the section as the ‘Secretaries’) shall
10 jointly develop a quality measurement system for the pur-
11 pose of measuring the quality of care patients receive.

12 “(b) REQUIREMENTS.—The Secretaries shall ensure
13 that the quality measurement system developed under sub-
14 section (a) comply with the following:

15 “(1) MEASURES.—

16 “(A) IN GENERAL.—Subject to subpara-
17 graph (B), the Secretaries shall select measures
18 of quality to be used by the Secretaries under
19 the systems.

20 “(B) REQUIREMENTS.—In selecting the
21 measures to be used under each system pursu-
22 ant to subparagraph (A), the Secretaries shall,
23 to the extent feasible, ensure that—

24 “(i) such measures are evidence
25 based, reliable and valid;

1 “(ii) such measures include measures
2 of process, structure, patient experience,
3 efficiency, and equity; and

4 “(iii) such measures include measures
5 of overuse, underuse, and misuse of health
6 care items and services.

7 “(2) PRIORITIES.—In developing the system
8 under subsection (a), the Secretaries shall ensure
9 that priority is given to—

10 “(A) measures with the greatest potential
11 impact for improving the quality and efficiency
12 of care provided under Federal programs;

13 “(B) measures that may be rapidly imple-
14 mented by group health plans, health insurance
15 issuers, physicians, hospitals, nursing homes,
16 long-term care providers, and other providers;
17 and

18 “(C) measures which may inform health
19 care decisions made by consumers and patients.

20 “(3) WEIGHTS OF MEASURES.—The Secretaries
21 shall assign weights to the measures used by the
22 Secretaries under each system established under
23 subsection (a).

24 “(4) RISK ADJUSTMENT.—The Secretaries shall
25 establish procedures to account for differences in pa-

1 tient health status, patient characteristics, and geo-
2 graphic location. To the extent practicable, such pro-
3 cedures shall recognize existing procedures.

4 “(5) MAINTENANCE.—The Secretaries shall, as
5 determined appropriate, but in no case more often
6 than once during each 12-month period, update the
7 quality measurement systems developed under sub-
8 section (a), including through—

9 “(A) the addition of more accurate and
10 precise measures under the systems and the re-
11 tirement of existing outdated measures under
12 the systems; and

13 “(B) the refinement of the weights as-
14 signed to measures under the systems.

15 “(c) REQUIRED CONSIDERATIONS IN DEVELOPING
16 AND UPDATING THE SYSTEMS.—In developing and updat-
17 ing the quality measurement systems under this section,
18 the Secretaries shall—

19 “(1) consult with, and take into account the
20 recommendations of, the entity that the Secretaries
21 has an arrangement with under subsection (e);

22 “(2) consult with representatives of health care
23 providers, consumers, employers, and other individ-
24 uals and groups that are interested in the quality of
25 health care; and

1 “(3) take into account—

2 “(A) any demonstration or pilot program
3 conducted by the Secretaries relating to meas-
4 uring and rewarding quality and efficiency of
5 care;

6 “(B) any existing activities conducted by
7 the Secretaries relating to measuring and re-
8 warding quality and efficiency;

9 “(C) any existing activities conducted by
10 private entities including health insurance plans
11 and payors; and

12 “(D) the report by the Institute of Medi-
13 cine of the National Academy of Sciences under
14 section 238(b) of the Medicare Prescription
15 Drug, Improvement, and Modernization Act of
16 2003.

17 “(d) REQUIRED CONSIDERATIONS IN IMPLEMENTING
18 THE SYSTEMS.—In implementing the quality measure-
19 ment systems under this section, the Secretaries shall take
20 into account the recommendations of public-private enti-
21 ties—

22 “(1) that are established to examine issues of
23 data collection and reporting, including the feasi-
24 bility of collecting and reporting data on measures;
25 and

1 “(2) that involve representatives of health care
2 providers, consumers, employers, and other individ-
3 uals and groups that are interested in quality of
4 care.

5 “(e) ARRANGEMENT WITH AN ENTITY TO PROVIDE
6 ADVICE AND RECOMMENDATIONS.—

7 “(1) ARRANGEMENT.—On and after July 1,
8 2006, the Secretaries shall have in place an arrange-
9 ment with an entity that meets the requirements de-
10 scribed in paragraph (2) under which such entity
11 provides the Secretaries with advice on, and rec-
12 ommendations with respect to, the development and
13 updating of the quality measurement systems under
14 this section, including the assigning of weights to
15 the measures under subsection (b)(2).

16 “(2) REQUIREMENTS DESCRIBED.—The re-
17 quirements described in this paragraph are the fol-
18 lowing:

19 “(A) The entity is a private nonprofit enti-
20 ty governed by an executive director and a
21 board.

22 “(B) The members of the entity include
23 representatives of—

24 “(i) health insurance plans and pro-
25 viders with experience in the care of indi-

1 individuals with multiple complex chronic con-
2 ditions or groups representing such health
3 insurance plans and providers;

4 “(ii) groups representing patients and
5 consumers;

6 “(iii) purchasers and employers or
7 groups representing purchasers or employ-
8 ers;

9 “(iv) organizations that focus on qual-
10 ity improvement as well as the measure-
11 ment and reporting of quality measures;

12 “(v) State government health pro-
13 grams;

14 “(vi) individuals or entities skilled in
15 the conduct and interpretation of bio-
16 medical, health services, and health eco-
17 nomics research and with expertise in out-
18 comes and effectiveness research and tech-
19 nology assessment; and

20 “(vii) individuals or entities involved
21 in the development and establishment of
22 standards and certification for health in-
23 formation technology systems and clinical
24 data.

1 “(C) The membership of the entity is rep-
2 resentative of individuals with experience with
3 urban health care issues and individuals with
4 experience with rural and frontier health care
5 issues.

6 “(D) If the entity requires a fee for mem-
7 bership, the entity shall provide assurances to
8 the Secretaries that such fees are not a sub-
9 stantial barrier to participation in the entity’s
10 activities related to the arrangement with the
11 Secretaries.

12 “(E) The entity—

13 “(i) permits any member described in
14 subparagraph (B) to vote on matters of
15 the entity related to the arrangement with
16 the Secretary under paragraph (1); and

17 “(ii) ensures that member voting pro-
18 vides a balance among disparate stake-
19 holders, so that no member organization
20 described in subparagraph (B) unduly in-
21 fluences the outcome.

22 “(F) With respect to matters related to the
23 arrangement with the Secretary under para-
24 graph (1), the entity conducts its business in an

1 open and transparent manner and provides the
2 opportunity for public comment.

3 “(G) The entity operates as a voluntary
4 consensus standards setting organization as de-
5 fined for purposes of section 12(d) of the Na-
6 tional Technology Transfer and Advancement
7 Act of 1995 (Public Law 104–113) and Office
8 of Management and Budget Revised Circular
9 A–119 (published in the Federal Register on
10 February 10, 1998).

11 “(f) USE OF QUALITY MEASUREMENT SYSTEM.—

12 “(1) IN GENERAL.—For purposes of activities
13 conducted or supported by the Secretary under this
14 Act, the Secretary shall, to the extent practicable,
15 adopt and utilize the measurement system developed
16 under this section.

17 “(2) COLLABORATIVE AGREEMENTS.—With re-
18 spect to activities conducted or supported by the
19 Secretary under this Act, the Secretary may estab-
20 lish collaborative agreements with private entities,
21 including group health plans and health insurance
22 issuers, providers, purchasers, consumer organiza-
23 tions, and entities receiving a grant under section
24 2908, to—

1 “(A) encourage the use of the health care
2 quality measures adopted by the Secretary
3 under this section; and

4 “(B) foster uniformity between the health
5 care quality measures utilized by private enti-
6 ties.

7 “(g) DISSEMINATION OF INFORMATION.—Beginning
8 on January 1, 2008, in order to make comparative quality
9 information available to health care consumers, health
10 professionals, public health officials, researchers, and
11 other appropriate individuals and entities, the Secretary
12 shall provide for the aggregation and analysis of quality
13 measures collected under section 2905 and the dissemina-
14 tion of recommendations and best practices derived in part
15 from such analysis.

16 “(h) TECHNICAL ASSISTANCE.—The Secretary shall
17 provide technical assistance to public and private entities
18 to enable such entities to—

19 “(1) implement and use evidence-based guide-
20 lines with the greatest potential to improve health
21 care quality, efficiency, and patient safety; and

22 “(2) establish mechanisms for the rapid dis-
23 semination of information regarding evidence-based
24 guidelines with the greatest potential to improve
25 health care quality, efficiency, and patient safety.

1 **“SEC. 2909. APPLICABILITY OF PRIVACY AND SECURITY**
2 **REGULATIONS.**

3 “The regulations promulgated by the Secretary under
4 part C of title XI of the Social Security Act and sections
5 261, 262, 263, and 264 of the Health Insurance Port-
6 ability and Accountability Act of 1996 with respect to the
7 privacy, confidentiality, and security of health information
8 shall—

9 “(1) apply to any health information stored or
10 transmitted in an electronic format on or after the
11 date of enactment of this title; and

12 “(2) apply to the implementation of standards,
13 programs, and activities under this title.

14 **“SEC. 2910. STUDY OF REIMBURSEMENT INCENTIVES.**

15 “The Secretary shall carry out, or contract with a
16 private entity to carry out, a study that examines methods
17 to create efficient reimbursement incentives for improving
18 health care quality in Federally qualified health centers,
19 rural health clinics, and free clinics.”.

20 **SEC. 3. HEALTH INFORMATION TECHNOLOGY RESOURCE**
21 **CENTER.**

22 Section 914 of the Public Health Service Act (42
23 U.S.C. 299b–3) is amended by adding at the end the fol-
24 lowing:

25 “(d) CENTER FOR BEST PRACTICES.—

1 “(1) IN GENERAL.—The Secretary, acting
2 through the Director, shall develop a Center for Best
3 Practices to provide technical assistance and develop
4 best practices to support and accelerate efforts to
5 adopt, implement, and effectively use interoperable
6 health information technology in compliance with
7 section 2903 and 2908.

8 “(2) CENTER FOR BEST PRACTICES.—

9 “(A) IN GENERAL.—The Center shall sup-
10 port activities to meet goals, including—

11 “(i) providing for the widespread
12 adoption of interoperable health informa-
13 tion technology;

14 “(ii) providing for the establishment
15 of regional and local health information
16 networks to facilitate the development of
17 interoperability across health care settings
18 and improve the quality of health care;

19 “(iii) the development of solutions to
20 barriers to the exchange of electronic
21 health information; or

22 “(iv) other activities identified by the
23 States, local or regional health information
24 networks, or health care stakeholders as a

1 focus for developing and sharing best prac-
2 tices.

3 “(B) PURPOSES.—The purpose of the Cen-
4 ter is to—

5 “(i) provide a forum for the exchange
6 of knowledge and experience;

7 “(ii) accelerate the transfer of lessons
8 learned from existing public and private
9 sector initiatives, including those currently
10 receiving Federal financial support;

11 “(iii) assemble, analyze, and widely
12 disseminate evidence and experience re-
13 lated to the adoption, implementation, and
14 effective use of interoperable health infor-
15 mation technology; and

16 “(iv) assure the timely provision of
17 technical and expert assistance from the
18 Agency and its contractors.

19 “(C) SUPPORT FOR ACTIVITIES.—To pro-
20 vide support for the activities of the Center, the
21 Director shall modify the requirements, if nec-
22 essary, that apply to the National Resource
23 Center for Health Information Technology to
24 provide the necessary infrastructure to support
25 the duties and activities of the Center and fa-

1 facilitate information exchange across the public
2 and private sectors.

3 “(3) TECHNICAL ASSISTANCE TELEPHONE
4 NUMBER OR WEBSITE.—The Secretary shall estab-
5 lish a toll-free telephone number or Internet website
6 to provide health care providers and patients with a
7 single point of contact to—

8 “(A) learn about Federal grants and tech-
9 nical assistance services related to interoperable
10 health information technology;

11 “(B) learn about qualified health informa-
12 tion technology and the quality measurement
13 system adopted by the Federal Government
14 under sections 2903 and 2908;

15 “(C) learn about regional and local health
16 information networks for assistance with health
17 information technology; and

18 “(D) disseminate additional information
19 determined by the Secretary.

20 “(4) AUTHORIZATION OF APPROPRIATIONS.—
21 There are authorized to be appropriated to carry out
22 this subsection, such sums as may be necessary for
23 each of fiscal years 2006 through 2010.”.

1 **SEC. 4. REAUTHORIZATION OF INCENTIVE GRANTS RE-**
2 **GARDING TELEMEDICINE.**

3 Section 330L(b) of the Public Health Service Act (42
4 U.S.C. 254c-18(b)) is amended by striking “2002 through
5 2006” and inserting “2006 through 2010”.

○