I

108TH CONGRESS
2D SESSION

H. R. 4880

To improve the quality, efficiency, standards, and technology of health care, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JULY 21, 2004

Mr. KENNEDY of Rhode Island introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To improve the quality, efficiency, standards, and technology of health care, 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 ''Josie King Act of 2004'' or the ''Quality, Efficiency, Standards, and Technology for Health Care Transformation Act of 2004''.

SEC. 2. DEFINITION.

For purposes of this Act, the term ''Secretary'' means the Secretary of Health and Human Services.

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TITLE I—NATIONAL HEALTH INFORMATION INFRASTRUCTURE

SEC. 101. PURPOSE.

The Secretary of Health and Human Services shall implement this title with a view to developing a national health information infrastructure.

SEC. 102. HEALTH INFORMATION TECHNOLOGY GRANTS.

(a) PHASE I GRANTS.—

(1) GRANTS.—The Secretary may make not more than 20 grants to health information infrastructure organizations to enable each grantee to develop and implement over a 4-year period a community health information technology plan that provides for a health information exchange to serve a geographic area in 1 or more States.

(2) USE OF FUNDS.—The Secretary may not make a grant to a health information infrastructure organization under this section unless the organization agrees to use the grant—

(A) in the first year of the grant, to develop a community health information technology plan described in paragraph (3) for submission to the Secretary under paragraph (4); and

(B) in each year of the grant, but not later than the second year of the grant, to implement a health information infrastructure, including a health information exchange, in accordance with the plan.

(3) COMMUNITY HEALTH INFORMATION TECHNOLOGY PLAN.—

(A) IN GENERAL.—A community health information technology plan shall provide for the establishment and implementation in a specified geographic area of a health information infrastructure that—

(i) includes a health information exchange that allows the seamless, secure, electronic sharing of health information among health care providers and other authorized users;

(ii) provides consumers with secure, electronic access to their own health information;

(iii) meets data standards for interoperability adopted by the Secretary, including any standards providing for interoperability among health information exchanges;

(iv) meets the privacy requirements of subsection (d);

(v) provides such public health surveillance and reporting capability as the Secretary requires;

(vi) allows for such reporting of, and access to, health information for purposes of research (other than individually identifiable health information) as the Secretary requires; and

(vii) allows for the reporting of health information (other than individually identifiable health information) to the database established under section 304 for the purpose of health care provider performance measurement in such form as required by the Secretary.

(B) CONTENTS.—A community health information technology plan shall—

(i) be developed with the participation and widespread support of the health care community, including all stakeholders (including small physician groups), of the geographic area to be served by the grantee's health information exchange;

(ii) describe the technologies and systems, including interoperability data standards, that will be used to establish a health information exchange consistent with paragraph (A)(i) and the technological requirements and support that will be necessary for health care providers to participate in the health information exchange;

(iii) establish how health care stakeholders will share the costs of health information technology investments required by the community health information technology plan, including the costs of implementing and maintaining new systems in physicians offices, hospitals, laboratories, community health centers, pharmacies, and other facilities of health care providers;

(iv) establish how administrative and clinical savings resulting from widespread use of new health information technology will be accounted for and distributed among health care stakeholders;

(v) explain how the health information infrastructure organization involved will ensure widespread participation by health

care providers (especially small physician groups) in the grantee's health information exchange and what support and assistance will be available to physicians seeking to integrate health information technologies into their practices;

(vi) describe how patients and caregivers who are not health care providers will be able to access and utilize the health information infrastructure;

(vii) establish how the health information infrastructure will be sustained over time, including anticipated sources of revenue;

(viii) explain how the grantee's health information exchange will protect patient privacy and maintain security;

(ix) explain how the grantee will ensure the participation of health care providers serving minority communities, including communities in which English is not the primary language spoken; and

(x) require that the grantee's health information exchange is certified by the Secretary under this section.

(4) APPROVAL OF PLAN.—

(A) SUBMISSION.—Not later than the end of the first year for which a health information infrastructure organization receives a grant under this subsection, the organization shall submit its community health information technology plan to the Secretary.

(B) APPROVAL.—The Secretary shall approve or disapprove each community health information technology plan submitted to the Secretary under this paragraph based on whether the plan complies with the requirements of this subsection.

(C) EFFECT OF FAILURE TO APPROVE.—The Secretary may not make any payment under this subsection to a health information infrastructure organization for the second, third, or fourth year for which the organization receives a grant unless the Secretary has approved the organization's community health information technology plan.

(5) SELECTION.—In selecting grant recipients under this section, the Secretary shall take into account the extent to which an applicant intends to develop a community health information technology

plan that covers a complete medical market area (as defined by the Secretary), geographical diversity, extent of stakeholder participation, health care provider participation commitments, capacity to measure quality and efficiency improvements, and replicability.

(b) PHASE II GRANTS.—

(1) GRANTS.—For the purpose described in paragraph (2), the Secretary shall make a grant under this subsection to each State that agrees to comply with the requirements of this subsection.

(2) PURPOSE.—A funding agreement for a grant under this subsection is that the State involved will use the grant only for making subgrants to health information infrastructure organizations for the purpose of—

(A) maintaining and upgrading existing health information exchanges;

(B) replicating existing health information exchanges to develop and implement new health information exchanges in areas not previously served by an exchange in accordance with the process and requirements described in subsection (a);

(C) including additional stakeholders in the health information exchanges;

(D) working with entities in neighboring States to expand health information exchanges on a regional basis; and

(E) connecting health information exchanges with public health and bioterrorism surveillance programs, including those of the Centers for Disease Control and Prevention.

(3) PRIVACY.—A funding agreement for a grant under this subsection is that the State involved must require that any infrastructure funded in whole or in part under this subsection must meet the privacy requirements of subsection (d).

(4) CERTIFICATION.—A funding agreement for a grant under this subsection is that the State involved will require that each health information exchange funded with the grant is certified by the Secretary under this section.

(5) REPORTS.—A funding agreement for a grant under this subsection is that the State involved will submit an annual report to the Secretary on the activities of the State under this subsection, including—

(A) the status of existing health information exchanges in the State; and

(B) the development and implementation of new health information exchanges in the State in areas not previously served by an exchange.

(6) ALLOCATION OF FUNDS.—Of the amount appropriated for each fiscal year to carry out this subsection, the Secretary shall use such appropriated amount to award a grant to each State receiving a grant under this subsection in an amount that bears the same relation to the appropriated amount as the number of physicians and hospitals in the State bears to the total number of physicians and hospitals in all such States.

(c) PHASE III GRANTS.—The Secretary shall continue to make grants to States in accordance with the provisions of subsection (b), except that—

(1) grants under this subsection shall be used primarily to maintain or upgrade existing health information exchanges; and

(2) the Secretary may not make a grant to a State under this subsection if less than 75 percent of the health care providers in the State are participating in a health information exchange.

(d) PRIVACY.—Any health information infrastructure funded in whole or in part under this section shall—

(1) comply with the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2(d));

(2) allow patients to exclude their health information from the health information exchange;

(3) give patients the option of allowing only designated health care providers to access their personally identifiable information concerning diagnosis and treatment of sexually transmitted diseases, addiction, and mental illnesses;

(4) allow health care providers to access individually identifiable health information through health information exchanges only for reasonable purposes related to diagnosis and treatment;

(5) allow other persons to access individually identifiable health information available through health information exchanges only with express patient consent; and

(6) require health care providers, in making a transmission of individually identifiable health information to payers through the health information infrastructure, to restrict the transmission to the min-

imum amount of information necessary for payment of the claim involved.

(e) APPLICATION.—To seek a grant under this section, an applicant shall submit an application to the Secretary in such form, in such manner, and containing such information and assurances as the Secretary may require.

(f) TECHNICAL ASSISTANCE.—

(1) IN GENERAL.—The Secretary shall provide to health information infrastructure organizations such technical assistance as the Secretary deems appropriate to carry out this section, including assistance relating to questions of governance, financing, and technological approaches to the creation of health information infrastructure.

(2) NATIONAL TECHNICAL ASSISTANCE CENTER.—

(A) ESTABLISHMENT.—The Director of the Agency for Healthcare Resources and Quality shall establish and maintain a national technical assistance center to provide assistance to physicians described in subparagraph (B) to facilitate successful adoption of health information technologies and participation in the development and implementation of community

health information technology plans by such physicians.

(B) PHYSICIANS.—The national technical assistance center shall provide assistance to physicians in geographical areas served by a health information infrastructure organization with a phase I grant under subsection (a).

(C) PRIORITY.—In providing assistance to physicians under this paragraph, the national technical assistance centers shall—

(i) give priority to physicians in small physician groups; and

(ii) as resources allow, provide assistance to physicians in larger groups.

(D) REQUIREMENTS.—Technical assistance provided under this paragraph shall, at a minimum, include the following:

(i) A clearinghouse of best practices, guidelines, and implementation strategies directed at the small medical practices that plan to adopt electronic medical records and other health information technologies.

(ii) A change management tool kit to enable physicians and their office staffs to successfully prepare practice workflows for

electronic medical record adoption, to receive guidance in the selection of vendors of health information technology products and services that are appropriate within the context of the individual practice and the community setting, to implement health information technology solutions and manage the project at the practice level, and to address the ongoing need for upgrades, maintenance, and security of office-based health information technologies.

(iii) The capability to provide consultations and advice to small medical practices to facilitate adoption of health information technologies.

(g) CERTIFICATION.—Not later than the date that is 1 year after the date of the enactment of this Act, the Secretary shall establish a program of certifying health information infrastructures that are in compliance with the requirements of subsection (a)(3)(A) and any other requirements of the national health information infrastructure as established by the Secretary.

(h) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—To carry out the provisions of this section other than subsection (f)(2), there are authorized to be appropriated—

(A) for phase I grants under subsection (a), $55,000,000 for fiscal year 2005 and $167,000,000 for each of fiscal years 2006, 2007, and 2008;

(B) for phase II grants under subsection (b), $400,000,000 for each of fiscal years 2009 through 2013; and

(C) for phase III grants under subsection (c), such sums as may be necessary for fiscal year 2014 and each subsequent fiscal year.

(2) TECHNICAL ASSISTANCE.—

(A) IN GENERAL.—Of the amount appropriated to carry out this section for a fiscal year, not more than than 10 percent of such amount or $5,000,000, whichever is lesser, may be used to provide technical assistance under subsection (f)(1).

(B) NATIONAL TECHNICAL ASSISTANCE CENTER.—To carry out subsection (f)(2), there is authorized to be appropriated $2,500,000 for each of fiscal years 2005 through 2008.

SEC. 103. STANDARDS FOR INTEROPERABILITY OF HEALTH INFORMATION TECHNOLOGY SYSTEMS.

(a) STANDARDS.—Not later than 1 year after the date of the enactment of this Act, after considering the recommendations of the Working Group, the Secretary of Health and Human Services, the Secretary of Defense, and the Secretary of Veterans Affairs, acting jointly, shall adopt data standards for the interoperability of health information technology systems.

(b) PERIODIC REVIEW.—The Secretary of Health and Human Services, the Secretary of Defense, and the Secretary of Veterans Affairs, acting jointly, shall periodically review the data standards adopted under subsection (a) and, as appropriate, revise such standards.

(c) APPLICATION.—The Secretary of Health and Human Services, the Secretary of Defense, and the Secretary of Veterans Affairs shall require that each program using health information technology of the Department of Health and Human Services, the Department of Defense, and the Department of Veterans Affairs, respectively, complies with the data standards adopted under subsection (a).

(d) WORKING GROUP.—

(1) ESTABLISHMENT.—The Secretary of Health and Human Services shall convene a Working Group to formulate recommendations on the adoption of

data standards for the interoperability of health information technology systems.

(2) MEMBERSHIP.—The members of the Working Group shall include the following:

(A) Health informatics experts from the Department of Defense, the Department of Health and Humans Services, the Department of Veterans Affairs, the Indian Health Service, and the private sector.

(B) Practicing physicians.

(C) Nurses.

(D) Representatives of other health care providers.

(E) Hospital administrators and hospital chief information officers.

(F) Representatives of standards development organizations.

(G) Representatives of standards development organizations.

(H) Representatives of the Agency for Healthcare Research and Quality.

(I) Representatives of the National Library of Medicine.

(J) Other individuals, as determined appropriate by the Secretary, with expertise rel-

evant to recommending data standards for the interoperability of health information technology systems.

(3) DUTIES.—The Working Group shall formulate recommendations to the Secretary of Health and Human Services, the Secretary of Defense, and the Secretary of Veterans Affairs on the adoption of data standards for the interoperability of health information technology systems, including recommendations on standards for each of the following:

(A) Components of electronic medical records.

(B) Interchange of clinical data, including, with a patient's consent, the sharing of patient data—

(i) across health care provider and community boundaries; and

(ii) between health care providers and patients.

(C) Terminologies.

(D) Medical knowledge representation.

(E) Computerized physician order entry.

(F) Privacy, security, and authentication of health information.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

(1) $5,000,000 for each of fiscal years 2005 and 2006; and

(2) $2,000,000 for fiscal year 2007 and each subsequent fiscal year.

SEC. 104. LOANS.

(a) IN GENERAL.—The Secretary may make loans to health information infrastructure organizations that receive a phase I grant under section 102(a) or a phase II subgrant under section 102(b) to provide additional funding for activities under the grant, including funding for the costs of—

(1) developing a community health information technology plan under section 102(a)(3); and

(2) implementing technology investments, training, and workflow reengineering under the plan.

(b) TERMS AND CONDITIONS.—Each loan under this section shall be subject to such terms and conditions as the Secretary deems appropriate, except that—

(1) the repayment period of each such loan may not exceed 10 years;

(2) any technology investments paid for in whole or in part with funds from the loan must com-

ply with the data standards for the interoperability of health information technology systems adopted by the Secretary under section 103;

(3) any technology investments paid for in whole or in part with funds from the loan must comply with the privacy requirements of section 102(d); and

(4) the Secretary shall require the health information infrastructure organization involved to provide to the Secretary an annual accounting of loan funds.

SEC. 105. SAFE HARBOR FOR EQUIPMENT AND SERVICES PROVIDED FOR THE DEVELOPMENT OR IMPLEMENTATION OF A HEALTH INFORMATION INFRASTRUCTURE.

Paragraph (3) of section 1128B(b) of the Social Security Act (42 U.S.C. 1320a–7b(b)) is amended—

(1) by striking the period at the end of the first subparagraph (H) and inserting a semicolon;

(2) by redesignating the second subparagraph (H) as subparagraph (I);

(3) by striking the period at the end of subparagraph (I) (as so redesignated) and inserting ''; and''; and

(4) by adding at the end the following:

''(J) the provision of any equipment or services that are appropriate for the development or implementation of a health information infrastructure under section 102 of the Quality, Efficiency, Standards, and Technology for Health Care Transformation Act of 2004, including the provision of hardware, software, and services necessary to participate in a health information exchange so long as such equipment or services are not provided in any manner that takes into account the volume, or value, of referrals or other business generated between the parties.''.

SEC. 106. EXCEPTION TO MEDICARE LIMITATIONS ON PHYSICIAN SELF-REFERRAL.

Section 1877(e) of the Social Security Act (42 U.S.C. 1395nn(e)) is amended by adding at the end the following new paragraph:

''(9) DEVELOPMENT OR IMPLEMENTATION OF A HEALTH INFORMATION INFRASTRUCTURE.—The provision of any equipment or services as appropriate for the development or implementation of a health information infrastructure under section 102 of the Quality, Efficiency, Standards, and Technology for Health Care Transformation Act of 2004,

including the provision of hardware, software, and services necessary to participate in a health information exchange so long as such equipment or services are not provided in any manner that takes into account the volume or value of referrals or other business generated between the parties.''.

SEC. 107. ADJUSTMENTS TO MEDICARE PAYMENTS TO PROVIDERS OF SERVICE AND SUPPLIERS PARTICIPATING IN HEALTH INFORMATION EXCHANGES.

(a) IN GENERAL.—The Secretary shall establish a methodology for making adjustments in payment amounts under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) made to providers of services and suppliers who furnish items or services for which payment is made under that title who—

(1) participate in a health information exchange certified by the Secretary under section 103(b); or

(2) in the course of furnishing items and services for which payment may be made under such title, use information technology with patient-specific applications that the Secretary determines improve the quality and accuracy of clinical decision-making (such as electronic medical records and computerized physician order entry).

(b) ESTABLISHMENT AND MODIFICATION OF CODES.—The methodology under subsection (a) shall—

(1) include the establishment of new codes, modification of existing codes, and adjustment of evaluation and management modifiers to such codes that take into account the costs of acquiring, using, and maintaining information technology with patient-specific applications; and

(2) take into account estimated aggregate annual savings in overall payments under such title XVIII attributable to the use of information technology with patient-specific applications.

(c) DURATION.—The Secretary may reduce or eliminate adjustments established made to subsection (a) as payment methodologies under title XVIII of the Social Security Act are adjusted to reflect provider quality and efficiency.

(d) RULE OF CONSTRUCTION.—In making national coverage determinations under section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) with respect to maintaining information technology with patient-specific applications, in determining whether the information technology is reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, the Secretary shall consider

whether the information technology improves clinical outcomes or cost-effectiveness of treatment.

(e) DEFINITIONS.—In this section:

(1) PROVIDER OF SERVICES.—The term ''provider of services'' has the meaning given such term under section 1861(u) of the Social Security Act (42 U.S.C. 1395x(u)).

(2) SUPPLIER.—The term ''supplier'' has the meaning given such term under section 1861(d) of such Act (42 U.S.C. 1395x(d)).

SEC. 108. MEDICAID PAYMENTS FOR INFORMATION INFRASTRUCTURE FOR HEALTH INFORMATION EXCHANGE AND INFORMATION TECHNOLOGY.

(a) PAYMENT.—In the case of a State that provides funding under a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) for the design, development, and installation of information infrastructure consisting of a health information exchange and information technology operated by health care providers pursuant to a community health information technology plan approved by the Secretary under section 102, the Secretary shall make matching payments to States under section 1903(a) of such Act (42 U.S.C. 1396b(a)) for such funding.

(b) 90 PERCENT FMAP FOR PHASE I GRANTS.—In addition to payment amounts provided for in subsection (a), for calendar quarters occurring during the first three years during which a State provides funding referred to in subsection (a), the Secretary shall provide for payment to such State at the rate provided for under section 1903(a)(3)(A)(i) of such Act (42 U.S.C. 1396b(a)(3)(A)(i)).

SEC. 109. DEFINITIONS.

In this title:

(1) The term ''health care provider'' means an entity involved in consultation, prevention, diagnosis, and treatment, including but not limited to a physician group, physician in individual practice, hospital, community health center, skilled nursing facility, laboratory, imaging center, or pharmacy.

(2) The term ''health information infrastructure organization'' means an organization that—

(A) facilitates the drafting and implementation of a community health information infrastructure plan for a given geographic area in 1 or more States;

(B) with respect to each area to be served by the organization with a grant under this section, is designated by the Governors of the

States involved as the exclusive health information infrastructure organization for that area; and

(C) is governed by a board that—

(i) includes representatives of health care insurers and other third party payors, government health care programs, employers, physicians and other health care providers, hospitals, and consumers; and

(ii) may include representatives of organized labor.

(3) The term ''physician'' has the meaning given to that term in section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)).

(4) The term ''small physician group'' means a physician practice group of 10 or fewer physicians.

(5) The term ''State'' includes the 50 States and the District of Columbia.

(6) The term ''Working Group'' means the working group convened under section 103.

TITLE II—HEALTH CARE OUTCOMES, BEST PRACTICES, AND EFFICIENCY

SEC. 201. RESEARCH ON OUTCOMES OF HEALTH CARE ITEMS AND SERVICES.

Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 299b–7) is amended—

(1) in subsection (a)—

(A) in clause (i) of paragraph (1)(A), by inserting ''cost-effectiveness,'' before ''comparative clinical effectiveness,'';

(B) by striking paragraph (2) and inserting the following:

''(2) PRIORITIES.—In carrying out this section, the Secretary shall adopt and implement the priorities established by the Consortium for Health Outcomes Research Priorities under section 202 of the Quality, Efficiency, Standards, and Technology for Health Care Transformation Act of 2004.''; and

(C) in clause (i) of paragraph (3)(A), by inserting ''cost-effectiveness,'' before ''comparative clinical effectiveness,'';

(2) by striking subsection (d);

(3) in subsection (e), by inserting ''$150,000,000 for fiscal year 2005, $250,000,000 for fiscal year 2006, $400,000,000 for fiscal year 2007, $750,000,000 for fiscal year 2008, $1,000,000,000 for fiscal year 2009,'' before ''and such sums as may be necessary for each fiscal year thereafter''; and

(4) by redesignating subsection (e) as subsection (d).

SEC. 202. CONSORTIUM FOR HEALTH OUTCOMES RESEARCH PRIORITIES.

(a) ESTABLISHMENT.—The Director of the Agency for Healthcare Research and Quality shall enter into an agreement with the Institute of Medicine to establish the Consortium for Health Outcomes Research Priorities.

(b) MEMBERS.—

(1) IN GENERAL.—The Consortium shall be composed of the ex officio members listed in paragraph (2) and the members appointed by the Institute of Medicine under paragraph (3).

(2) EX OFFICIO MEMBERS.—The ex officio members of the Consortium shall include the following:

(A) The Administrator of the Centers for Medicare and Medicaid Services.

(B) The Commissioner of Food and Drugs.

(C) The Director of the Agency for Healthcare Research and Quality.

(D) The Director of the Centers for Disease Control and Prevention.

(E) The Director of the Indian Health Service.

(F) The Director of the National Institutes of Health.

(G) The Assistant Secretary of Defense for Health Affairs.

(H) The Under Secretary for Health, Department of Veterans Affairs.

(3) APPOINTED MEMBERS.—The members of the Consortium appointed by the Institute of Medicine shall include the following:

(A) Academics.

(B) Practicing physicians.

(C) Representatives of the following:

(i) Hospitals.

(ii) Drug companies.

(iii) Device companies.

(iv) Health care insurers, including State medicaid programs under title XIX

of the Social Security Act (42 U.S.C. 1396 et seq.).

(v) Employers or employer groups with a history of supporting health care quality initiatives.

(vi) Patient advocacy groups.

(vii) Professional societies.

(viii) Health foundations.

(4) MAJORITY OF MEMBERS.—A majority of the members of the Consortium shall be appointed by the Institute of Medicine under paragraph (3).

(c) DUTIES.—The Consortium shall—

(1) establish research priorities under subsection (d); and

(2) carry out section 205 (relating to standardized measures of health care provider performance).

(d) RESEARCH PRIORITIES.—

(1) ESTABLISHMENT.—On an annual basis, the Consortium shall establish priorities for research conducted or supported by the Agency for Healthcare Research and Quality under section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 299b–7) (relating to the effectiveness and efficiency of health care items and services).

(2) CONSIDERATION.—In establishing research priorities under subsection (c)(1), the Consortium shall take into consideration—

(A) the extent to which health care items and services—

(i) impact large numbers of people; or

(ii) impose high health care costs; and

(B) the extent of the need for data with respect to diseases or conditions affected by those health care items and services.

(3) TRANSPARENCY.—In carrying out this section, the Consortium shall ensure that research priorities are established in a manner that is publicly transparent.

SEC. 203. CENTER FOR CLINICAL DECISION-SUPPORT TECHNOLOGY.

(a) ESTABLISHMENT.—The Director, in collaboration with the National Library of Medicine, shall establish and support by grant or contract a Center for Clinical Decision-Support Technology to enable health care providers across the United States to more efficiently and rapidly embed knowledge-based elements in their clinical information systems.

(b) DUTIES.—The Center for Clinical Decision-Support Technology shall—

(1) design and develop new approaches to knowledge organization, modeling, and decision support;

(2) develop standards and promote existing standards for guideline models, standard data sets, vocabularies, and interfaces among components of the decision-support system;

(3) build tools to facilitate the encoding of medical knowledge in a structured form to enable such knowledge to be used in patient-specific decision support, associated with other relevant evidence, updated and maintained, and adapted to local systems and environments;

(4) define and regularly update methods to determine the effectiveness of such tools, including the appropriateness of the knowledge, the ease of adaptation to local environments, and the success of the intended application in achieving specific goals;

(5) generalize or abstract the features of specific applications in the systems of the affiliated health care delivery organizations that have been found to be successful, but for which sharing and dissemination are not easily achieved, due to system-specific designs; and

(6) explore optimal interface approaches to access and use of knowledge resources for health care providers and consumers.

(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $2,000,000 for fiscal year 2005 and such sums as may be necessary for each subsequent fiscal year.

SEC. 204. SCHOLARSHIPS FOR STUDY IN HEALTH CARE QUALITY AND PATIENT SAFETY.

(a) PURPOSES.—The purposes of this section are to improve health care quality and patient safety and to achieve a corresponding reduction in health care costs by providing scholarships to future health care leaders for study in the fields of health care quality and patient safety.

(b) SCHOLARSHIPS.—For the purposes described in subsection (a), the Director may make grants to eligible institutions for the awarding of scholarships to physicians, nurses, other health care personnel, and administrators to enable such individuals to obtain a master's degree or a doctoral degree in the field of health care quality and patient safety.

(c) PRIORITY.—A condition on the receipt of a grant under this section is that the eligible institution, in award-

ing scholarships, will give priority to applicants whose studies will focus on—

(1) measuring, monitoring, and improving the clinical and financial performance of health care service organizations; or

(2) providing leadership for organizational change within the health care system.

(d) USE OF SCHOLARSHIPS.—A scholarship under this section may be used to pay the costs of all reasonable educational expenses, including tuition, fees, and books, and such stipends as the Director determines to be appropriate.

(e) FLEXIBILITY.—A condition on the receipt of a grant under this section is that the eligible institution will offer flexibility to scholarship recipients who desire to continue clinical practice while pursuing a course of study, including by allowing such recipients to pursue a course of study on a part-time basis.

(f) DEFINITION.—In this section:

(1) The terms ''accredited'' and ''school of public health'' have the meanings given to those terms in section 799B of the Public Health Service Act (42 U.S.C. 295p).

(2) The term ''eligible institution'' means an accredited school of public health offering a master's

degree or a doctoral degree in the field of health care quality and patient safety with a curriculum that—

(A) is interdisciplinary;

(B) includes coursework and training in—

(i) health services research;

(ii) health care quality;

(iii) decision analysis;

(iv) cost-benefit and cost-effectiveness analysis; and

(v) management skills and leadership; and

(C) includes fieldwork in a health care facility.

(g) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $2,000,000 for fiscal year 2005 and such sums as may be necessary for each subsequent fiscal year.

SEC. 205. STANDARDIZED MEASURES OF HEALTH CARE PROVIDER PERFORMANCE.

(a) PRIORITIES.—Not later than 1 year after the date of the enactment of this Act, the Consortium shall identify priorities for developing, updating, and endorsing standardized measures of health care provider performance under this section. Such priorities shall—

(1) first be developed for each of the 20 priority areas for improvement in health care quality specified in the report by the Institute of Medicine entitled ''Priority Areas for National Action: Transforming Health Care Quality'';

(2) include priorities for measures of health care provider performance based on adherence to evidence-based medicine, patient outcomes, efficiency, and patient satisfaction;

(3) include priorities for measures specific to a range of practice settings, including individual doctors and small physician groups;

(4) emphasize the development of reliable, risk-adjusted outcome measures; and

(5) be updated on an annual basis.

(b) DEVELOPMENT.—The Director shall enter into agreements with medical specialty societies, private accrediting organizations, and other appropriate organizations to develop and update measures of health care provider performance in accordance with the priorities identified under subsection (a).

(c) ENDORSEMENT.—

(1) IN GENERAL.—The Director shall enter into an agreement with the National Quality Forum for

the endorsement by such entity of standardized measures of health care provider performance.

(2) REQUIREMENTS.—The agreement entered into under this subsection shall require the National Quality Forum—

(A) to endorse standardized measures of health care provider performance for each of the 20 priority areas described in subsection (a)(1);

(B) to endorse other such measures over time consistent with the priorities identified under subsection (a); and

(C) to recommend aggregate measures of health care provider performance to create simplified comparisons of health care provider performance.

SEC. 206. DEFINITIONS.

In this title:

(1) The term ''Consortium'' means the Consortium for Health Outcomes Research Priorities established under section 202.

(2) The term ''Director'' means the Director of the Agency for Healthcare Research and Quality.

TITLE III—INCENTIVES FOR HEALTH CARE QUALITY

SEC. 301. ACCESS TO MEDICARE HEALTH CARE CLAIMS DATABASES.

(a) ACCESS BY HEALTH PLANS.—

(1) IN GENERAL.—The Center for Medicare and Medicaid Services shall make available to a group health plan, that meets the condition under paragraph (2), all data in the possession of the Secretary with respect to the most recent claims submitted to the Secretary for items and services furnished to medicare beneficiaries for which payment is made under title XVIII of the Social Security Act.

(2) CONDITION OF ACCESS.—The condition referred to in paragraph (1) for a group health plan to have access to data under that paragraph is that the group health plan contribute claims-based health care provider performance data to the health care provider performance database established under section 303.

(b) PRIVACY PROTECTIONS.—

(1) IN GENERAL.—A request under subsection (a) is subject to the provisions of the Health Insurance Portability and Accountability Act and the Privacy Act.

(2) SPECIFIC PROTECTIONS.—

(A) ENCRYPTION.—The Secretary shall ensure that any identification number of a beneficiary to which a claim relates is encrypted in a consistent fashion in order to access data with respect to that beneficiary for claims for items and services under each applicable part of title XVIII.

(B) DELETION OF PERSONAL IDENTIFYING INFORMATION.—The Secretary shall ensure that the data omits the name, date of birth, street address and the last two applicable postal codes of each of the beneficiaries.

(3) EXCLUSION OF CERTAIN DATA.—In the case of a provider of services or a supplier that submits a low volume of claims to the Secretary for items or services furnished to medicare beneficiaries, or in the case of certain rare medical conditions or treatments, the Secretary may exclude data with respect to such claims, conditions, or treatment from a request under subsection (a) in order to protect patient privacy.

(c) FORM OF REQUEST.—Requests under subsection (a) shall require such information, and be in such form, as the Secretary determines appropriate. Such a request

shall include the applicable period and areas for which such claims data is requested.

(d) FEE.—The Secretary may require the payment of a fee by each group health plan that submits a request under subsection (a) to offset administrative costs incurred by the Secretary in carrying out this section.

(e) AUTHORITY TO CONTRACT.—If the Secretary determines that data could be made available more promptly, the Secretary may enter into arrangements with private entities to merge data for claims under each part of title XVIII of the Social Security Act. The Secretary shall ensure that a unique encryption applies to each beneficiary encryption.

SEC. 302. INCORPORATION OF MEASURES OF HEALTH CARE PRACTITIONER PERFORMANCE IN FEDERAL PROGRAMS.

(a) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Defense, the Secretary of Health and Human Services, the Secretary of Veterans Affairs, and the Director of the Indian Health Service shall incorporate, to the extent practicable, measures of health care practitioner performance endorsed by the National Quality Forum into the health care programs of the Department of Defense, the Department of Health and Human Services, the Department of

Veterans Affairs, and the Indian Health Service, respectively for the purpose of improving program quality and efficiency.

(b) REPORT TO CONGRESS.—Not later than 18 months after the date of the enactment of this Act, each Federal official specified in subsection (a) shall submit a report to the Congress on the results of the official's activities under this section.

SEC. 303. INTERIM CLAIMS-BASED PRACTITIONER PERFORMANCE DATABASE.

(a) IN GENERAL.—Not later than the date that is 18 months after the date of the enactment of this Act, the Secretary shall establish a claims-based practitioner performance database that comprises de-indentified claims data under the medicare program under title XVIII of the Social Security Act and claims data from any group health plan that voluntarily submits de-identified health care claims data to the Secretary for such purpose.

(b) REQUIREMENT FOR PARTICIPATION BY FEHB PLANS.—The Director of the Office of Personnel Management shall require, as a condition under chapter 89 of title 5, United States Code, that each plan under contract with the Director under such chapter submit de-identified claims data to practitioner performance database.

(c) PERFORMANCE MEASUREMENTS.—Not later than 1 year after the date specified in subsection (a), and not less frequently than annually thereafter, the Secretary, from data in the database established under this section, shall prepare practitioner performance measurements. Such measurements shall—

(1) be based on performance measures endorsed by the National Quality Forum;

(2) measure—

(A) the performance of individual physicians, physician groups (if any), and hospitals; or

(B) if records are not available for measuring such performance, the performance of the smallest practitioner unit for which records are available; and

(3) be presented in such manner as the Secretary determines will accurately and clearly represent the comparative performance quality and efficiency of physicians, physician groups, and hospitals.

(d) PRIVACY PROTECTIONS.—The Secretary shall ensure that—

(1) any patient identifier is encrypted or omitted in a consistent fashion;

(2) the data omits the name, date of birth, street address and the last two applicable postal codes of each patient; and

(3) the amount of the charge for services furnished is omitted.

(e) REQUIREMENT FOR SUBMISSION OF DATA BY ALL GROUP HEALTH PLANS.—Not later than four years after the date referred to in subsection (a), each group health plan shall contribute de-indentified claims data necessary for performance measurement to the practitioner performance database established under subsection (a). As soon as practicable, the Secretary shall make available annual performance measures to the public.

(f) TERMINATION.—Beginning on the date that is 10 years after the date referred to in subsection (a), the Secretary shall discontinue the collection of data under this section.

SEC. 304. CLINICAL-BASED PRACTITIONER PERFORMANCE DATABASE.

(a) ESTABLISHMENT.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall establish a practitioner performance database that comprises data from any health care practitioner that voluntarily submits de-indentified health care data to the Secretary for such purpose.

(b) PRIVACY PROTECTIONS.—The Secretary shall require health care practitioners to encrypt or omit all individually identifiable patient information from data submitted to the Secretary under this section, including by ensuring that—

(1) any patient identifier is encrypted or omitted in a consistent fashion;

(2) the data omits the name, date of birth, street address, and the last 2 applicable postal codes of each patient; and

(3) the amount of the charge for services furnished is omitted.

(c) PERFORMANCE MEASUREMENTS.—Not later than 1 year after the date specified in subsection (a), and not less frequently than annually thereafter, the Secretary, from data in the database established under this section, shall prepare practitioner performance measurements. Such measurements shall—

(1) be based on performance measures endorsed by the National Quality Forum;

(2) measure—

(A) the performance of individual physicians, physician groups (if any), and hospitals; or

(B) if records are not available for measuring such performance, the performance of the smallest practitioner unit for which records are available; and

(3) be presented in such manner as the Secretary determines will accurately and clearly represent the comparative performance quality and efficiency of physicians, physician groups, and hospitals.

(d) CERTAIN PRACTITIONERS.—As a condition on any grant or subgrant awarded to a health information infrastructure organization under section 102, the Secretary shall require the organization to agree that the organization will not allow any health care practitioner to participate in a health information exchange established or implemented with the grant unless the practitioner submits claims data to the Secretary in accordance with this section.

SEC. 305. AVAILABILITY OF PERFORMANCE MEASUREMENTS AND DATA.

(a) PERFORMANCE MEASURES.—The Secretary shall make publicly available the practitioner performance measurements prepared under sections 303 and 304.

(b) DATA.—The Secretary shall restrict access to the data in the databases under sections 303 and 304 to individuals requesting such information in connection with re-

search conducted or supported by the Agency for Healthcare Research and Quality.

SEC. 306. USE OF HEALTH CARE PROVIDER PERFORMANCES MEASURE FOR PAY FOR PERFORMANCE.

(a) IN GENERAL.—The Secretary may provide for adjustments to payment systems under title XVIII of the Social Security Act based on performance measurements of physicians, physician groups, and institutional providers of services. Insofar as the Secretary exercises the authority under the preceding sentence, in the case of providers with both claims-based and clinical-based measurements, the Secretary shall use the clinical-based measurements for any pay-for-performance unless the provider elects to use claims-based measurements. In no case may an election under the preceding sentence be in effect after the date that is 6 years after the date of the enactment of this Act.

(b) MEDPAC RECOMMENDATIONS.—The Medicare Payment Advisory Commission shall include in the March 2007 report to Congress, and annually thereafter, specific recommendations for the amount of adjustments to payment systems and beneficiary cost-sharing under title XVIII of the Social Security Act based on performance measurements in order to share savings under such title

attributable to quality improvement with practitioners, to create incentives for better practitioner performance, and shift medicare beneficiary caseload to higher quality, more efficient practitioners.

(c) SENSE OF CONGRESS.—It is the sense of the Congress that the Director of the Office of Personnel Management should encourage plans with contracts under chapter 89 of title 5, United States Code, to include differential payments, differential cost-sharing, or both based on HHS practitioner performance measurements under section 303.

SEC. 307. STUDY COMPARING PRACTITIONER PERFORMANCE DATABASE.

Not later than 54 months after the date of the enactment of this Act, the Director of the Agency for Healthcare Research and Quality shall—

(1) conduct a study to compare the interim claims-based practitioner performance database established under section 303 with the clinical-based practitioner performance database established under section 304, including by assessing the scope, cause, and import of any differences between the 2 databases in practitioner performance measurement; and

(2) submit a report to the Congress on the results of the study.

SEC. 308. REGULATIONS ON AUDITING.

The Secretary shall establish regulations governing the audit of group health plans that submit data under section 303 and health care practitioners that submit data under section 304 for compliance with such sections.

SEC. 309. AHRQ ACCESS TO PRACTITIONER PERFORMANCE DATABASES.

The Director of the Agency for Healthcare Research and Quality shall have access to the data in the databases established under sections 303 and 304 for health outcomes research, including research conducted internally or by external researchers.

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