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# WIRED FOR HEALTH CARE QUALITY ACT

JULY 27, 2005.—Ordered to be printed

Mr. ENZI, from the Committee on Health, Education, Labor, and Pensions, submitted the following

## REPORT

[To accompany S. 1418]

The Committee on Health, Education, Labor, and Pensions, to which was referred the bill (S. 1418) 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, having considered the same, reports favorably thereon with an amendment in the nature of a substitute and recommends that the bill (as amended) do pass.

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## I. PURPOSE AND SUMMARY

The purpose of S. 1418, the "Wired for Health Care Quality Act" is to enhance the adoption of a nationwide interoperable health information technology system and to improve the quality and reduce the cost of health care in the United States.

The bill amends the Public Health Service Act by adding a new title, "Health Information Technology and Quality." Most importantly, the bill protects the privacy and security of health informa-

tion. The bill also permanently establishes the Office of the National Coordinator within the Office of the Secretary for Health and Human Services. The bill also formalizes the role of private entities in the standards-setting process by directing the Secretary to establish and chair the public-private American Health Information Collaborative. The bill authorizes three grant programs to facilitate the widespread adoption of interoperable health information technology. The legislation also authorizes competitive grants to carry out demonstration projects to develop academic curricula integrating qualified health information technology systems in the clinical education of health professionals. In order to improve health care quality, the bill tasks the Secretary with developing a quality measurement system in collaboration with other key Federal agencies. The bill also calls for two studies, one examining the variation among State laws that relate to the licensure, registration, and certification of medical professionals, and the other examining methods to create efficient reimbursement incentives for improving health care quality. Finally, the bill establishes a Health Information Technology Resource Center within the Agency for Health Care Research and Quality to provide technical assistance and develop best practices to support and accelerate efforts to adopt, implement, and effectively use interoperable health information technology.

## II. Background and Need for Legislation

The Institute of Medicine estimates that medical errors kill 45,000 to 98,000 Americans each year in hospitals. Additionally, a Rand study stated that adult Americans receive recommended care only 55 percent of the time. Nearly 30 percent of health care spending is for treatments that may not improve health status, may be redundant, or may be inappropriate for the patient's condition according to Dartmouth University researchers.

Some of the most serious challenges facing healthcare today—medical errors, inconsistent quality, and rising costs—can be addressed through the effective application of available health information technology linking all elements of the health care system and using the system to report performance against quality measures. Information sharing networks have the potential to enable decision support any where at any time, thus improving the quality of health care and reducing costs.

In April 2004, the President signed an Executive Order announcing his commitment to the promotion of health information technology to lower costs, reduce medical errors, improve quality of care, and provide better information for patients and physicians. In particular, the President called for widespread adoption of electronic health records and for health information to follow patients throughout their care in a seamless and secure manner.

This committee agrees that if we move from a paper-based health care system to secure electronic health records, we will reduce mistakes and save lives, time and money. This legislation will bring the government and the private sector together to make healthcare better, safer and more efficient by accelerating the widespread adoption of interoperable health information technology and quality measurement across our healthcare system.

Interoperability is a shared goal across the health care industry by payers, providers, vendors, and consumers. The national strategy for achieving interoperability of digital health information calls for Federal agencies—who pay more than one-third of all health care costs—to collaborate with private entities in developing and adopting an architecture, standards, certification process, and a method of governance for ongoing implementation of health IT. Once the market has structure, patients, providers, medical professionals, and vendors will be better able to innovate, create efficiencies, and improve care.

The legislation formalizes involvement of private entities in thestandards and policy-setting process by directing the Secretary to establish and chair the public-private American Health Information Collaborative, which shall be composed of representatives of the public and private sectors.

The committee aims to facilitate the development and national implementation of an interoperable health IT infrastructure that ensures patients' individually identifiable health information is secure and protected; improves health care quality, reduces medical errors, and advances the delivery of appropriate, evidence-based medical care; reduces health care costs resulting from inefficiency, medical errors, inappropriate care, and incomplete information; ensures appropriate information to guide medical decisions is available at the time and place of care; promotes a more effective marketplace, greater competition, and increased choice through the wider availability of accurate information on health care costs, quality, and outcomes; improves the coordination of care and information among hospitals, laboratories, physician offices, and other ambulatory care providers through an effective infrastructure for the secure and authorized exchange of health care information; improves public health reporting and facilitates the early identification and rapid response to public health threats and emergencies, including bioterror events and infectious disease outbreaks; and promotes prevention of chronic diseases.

For the last 2 years, HHS has supported its health information technology initiatives without specific lines of authorization. The committee believes it is critical to give HHS specific authorization but also provide the Secretary with flexibility to determine what is effective and to allocate that money accordingly.

The committee agrees that an investment in health information technology now will decrease healthcare costs over the long-term. This legislation targets Federal funding to those who need the most help updating and advancing health information technology.

## III. Legislative History and Committee Action

On July 18, 2005, Senators Enzi, Kennedy, Frist, Clinton, Alexander, Dodd, Burr, Harkin, Isakson, Milkulski, DeWine, Jeffords, Roberts, Bingaman, Murray, Bond, Hagel, Martinez, Talent, Nelson (FL), and Obama introduced S. 1418, the "Wired for Health Care Quality Act." On July 20, 2005, the committee held an executive session to consider S. 1418. After accepting a substitute amendment offered by Senator Enzi by unanimous voice vote, the committee approved S. 1418, as amended, by unanimous voice vote.

## IV. Explanation of Bill and Committee Views

In April 2004, by Executive Order, President George W. Bush established the Office of the National Coordinator for Health Information Technology, operating from the Office of the Secretary at the Department of Health and Human Services. The Office is charged with developing a blueprint for a nationwide interoperable health information technology infrastructure and coordinating health information technology policies and programs across the Federal Government.

This bill will permanently establish the Office in the Department. The duties of the Office include serving as a member of the public-private American Health Information Collaborative, serving as the primary advisor to the Secretary and the President on the health information technology policies and programs of the Federal Government, ensuring the adoption of standards for the electronic exchange of health information, and interacting with public and private stakeholders. In carrying out the activities of the Office, the National Coordinator shall work to ensure the security of patient health information and the electronic exchange of health information.

The Office will report to Congress on actions taken by the Federal Government and private entities to facilitate the electronic exchange of health information and describe barriers to the adoption of, and make recommendations to achieve full implementation of, a nationwide electronic health information system. The bill allows the Office to accept the detail of Federal employees from other Federal agencies to assist in their activities.

The bill also specifies that an additional purpose of the Office is to coordinate and develop a nationwide interoperable health information technology infrastructure that promotes the prevention of chronic disease. The committee believes the United States cannot address rising health care costs without preventing chronic disease. According to the Centers for Disease Control, the medical care costs of people with chronic diseases account for more than 75 percent of the Nation's $1.4 trillion medical care costs. In addition, chronic disease accounts for 70 percent of all death in the United States. The committee believes adoption and promotion of health information technology can lead to innovative interventions to prevent disease and reduce health care costs.

The legislation authorizes $5 million for each of fiscal years 2006 and 2007 for personnel compensation for the Office.

The Secretary has begun undertaking the activities outlined in this section of the legislation. It is the committee's intent not to require the duplication of Federal efforts with respect to the establishment of the Office.

The committee believes that the inclusion of decision support in an interoperable health information technology system is critical to reducing medical errors and improving the quality of care patients receive. For that reason, the committee included the incorporation of decision support in the definition of qualified health information technology. The definition clearly states that qualified health information technology means a computerized system and it is the intent of the committee that decision support be included in that system, but the committee recognizes that each potential component

(hardware or software) of a comprehensive interoperable health information technology system may not include a decision support feature. It is not the intention of the committee to restrict these components from participation in an interoperable qualified health information technology system, but rather to require that decision support be integrated within the system and available to any user.

The legislation formalizes involvement of private entities in the standards-setting process by directing the Secretary to establish and chair the public-private American Health Information Collaborative, which the bill specifies be composed of representatives of the public and private sectors.

It is the purpose of the Collaborative to advise the Secretary and recommend specific actions to achieve a nationwide interoperable health information technology infrastructure, and to serve as a forum for the participation of a broad range of stakeholders to provide input on achieving the interoperability of health information technology.

It is the intent of the committee to ensure that the Collaborative serve a dual purpose of recommending standards for the electronic exchange of health information and ongoing modifications to these standards and recommending uniform national policies facilitating the widespread adoption of interoperable health information. Given the unusually sensitive nature of health information and the complexity of the technical standards and policies needed to guide its use, it is imperative that a single entity be responsible for decisions related to both domains so they can be closely integrated. The Collaborative's policy recommendations are essential to the success of widespread adoption of interoperable health information technology. While the Collaborative will be the authority regarding matters in both domains, it may establish working groups within the Collaborative.

The Collaborative shall, among other things, advance and develop recommendations for the following issues: Protection of health information through appropriate privacy and security practices; measures to prevent unauthorized access to health information; methods to facilitate secure patient access to health information; the ongoing harmonization of industry-wide health information technology standards; recommendations for a nationwide health information technology infrastructure; the identification and prioritization of specific use cases for which health information technology is valuable, beneficial, and feasible; recommendations for the establishment of an entity to ensure the continuation of the functions of the Collaborative; and other policies determined appropriate by the Collaborative.

The committee finds great value for patients in viewing their own health records. In developing uniform, interoperable standards for health information, the Collaborative should examine standards for patient review and secure access of their health information. This would enhance the ability of patients to manage their own health care. It would reduce duplication of services and allow patients to be better health care consumers. Patients can play an important role in reducing medical errors, preventing over utilization of services, and improving quality.

The Collaborative shall strive for maximum cost-effectiveness by building on existing standards and policy work, establishing effi-

cient processes and minimizing the negative economic impact of any new requirements it defines. As a general principle, the Collaborative should seek existing solutions and minimal modifications, creating new solutions only as a last resort. Even so, some change will be required to ensure interoperability. The extent of such change must be determined using a defined process. To do so effectively requires close and continuous interaction with standards development organizations and other potential sources of relevant models for its own work.

The process to identify and specify these standards and policies must engage all affected stakeholders, as the credibility and compliance with the decisions of the Collaborative will ultimately depend on whether those who are affected by standards and policies were able to participate in the decision-making process. It is the intent of the committee to ensure a balance among all stakeholders, so that no member organization unduly influences recommendations from the Collaborative.

The Collaborative shall be composed of the Secretary (who shall serve as the chairperson), the Secretary of Defense, the Secretary of Veterans Affairs, the Secretary of Commerce, the National Coordinator for Health Information Technology, and representatives of other relevant agencies, as determined appropriate by the Secretary. Representatives from each of the following categories shall be appointed by the Secretary from nominations submitted by the public: consumer and patient organizations, experts in health information privacy and security, health care providers, health insurance plans or other third-party payers, standards development organizations, information technology vendors, purchasers and employers, and State or local government agencies or Indian tribes or tribal organizations.

In appointing members, the Secretary shall select individuals with expertise in health information privacy, health information security, health care quality and patient safety, data exchange and health information technology standards. Each representative should be a key decision-maker in his or her field and should have broad support from peers and related professional organizations.

Members shall serve 2-year terms, and those who are not considered full-time Federal employees will be paid a daily rate plus per diem. Private-sector members who serve as special government employees will be subject to financial disclosure and conflict of interest requirements. Some private-sector members may serve as industry representatives and will not be special government employees.

Because the legislation specifies that the Federal Advisory Committee Act (FACA) shall apply to the Collaborative (except that the term provided shall be 5 years), the Collaborative governance and administration will be transparent and accountable. The bill deems recommended by the Collaborative the standards adopted by the Consolidated Health Informatics Initiative. The bill also directs the Collaborative, on an ongoing basis, to recommend new standards for the electronic exchange of health information and modifications to existing standards, identify deficiencies and omissions in existing standards, and identify duplication and overlap in existing standards.

The bill directs the Secretary to provide for the adoption by the Federal Government of any standard or standards recommended by the Collaborative within 60 days after the issuance of such recommendation. The bill specifies the Secretary of Health and Human Services, the Secretary of Veterans Affairs, and the Secretary of Defense, in collaboration with representatives of other relevant Federal agencies, jointly review such recommendations.

The committee believes that when private entities contract with the government to provide healthcare services, as in the Federal Employee Health Benefits Plan or Medicare Advantage Plans, those entities should be able to exchange interoperable information with the Federal Government. To accomplish this under their contracts, private entities must adopt the same standards as the Federal Government. However, this requirement only applies to the external exchange of information. The committee does not intend for private entities to have to adopt the government's standards for their internal business processes, even if those processes ultimately support the exchange of information under the contract.

Not later than 1 year after the adoption by the Federal Government of a recommended standard, no Federal agency shall expend Federal funds for the purchase of any form of health information technology system for clinical care or for the electronic retrieval, storage, or exchange of health information that is not consistent with applicable standards adopted by the Federal Government. The committee believes it is critical that the Federal Government comply with the data standards recommended by the Collaborative in order to create a nationwide interoperable health information technology infrastructure.

The legislation requires the Secretary of HHS to implement procedures to enable the Department to accept the electronic submission of data. Participation in the electronic submission of reports utilizing standards is voluntary for private entities, but the Department shall permit such submission. The provision is intended to provide private entities the option of submitting data electronically so that reporting becomes simply another function of an interoperable health information technology system.

The bill requires the Secretary annually to submit a report to Congress that describes actions taken to achieve a nationwide system for the exchange of health information, describes barriers to the adoption of such a nationwide system, contains recommendations to achieve full implementation of a nationwide system, and contains a plan for the establishment of an entity to ensure the continuation of the functions of the Collaborative.

The legislation authorizes $4 million for each of fiscal years 2006 and 2007 for operating the Collaborative.

The Secretary has begun undertaking the activities outlined in this section of the legislation. It is the committee's intent not to require the duplication of Federal efforts with respect to the establishment of the Collaborative.

The adoption of standards is an important component of establishing consistent and common content and communication between health information technology systems. However, consistent and common use of adopted standards is another vital piece of establishing a nationwide interoperable health information system. This bill directs the Secretary or his designee, based upon the rec-

ommendation of the Collaborative, to establish criteria for the implementation and certification of standards adopted by the Federal Government. Additionally, the bill authorizes the Secretary to recognize a private entity to assist with the development of criteria for the implementation of the standards and certification of products for compliance with the standards.

The committee believes there are significant barriers to widespread adoption of interoperable health information technology. One of the primary barriers is the current lack of agreed-upon standards and common implementation guides and a certification process. This committee believes this bill addresses those factors in a way that appropriately incorporates involvement of both the public and private sectors.

The committee recognizes that the other major barrier to widespread adoption of health information technology in the U.S. health care system is the high cost of such technology. The typical cost of purchasing a robust health information technology system for a solo or group practitioner is estimated to be thousands of dollars per provider. In addition to this, there are typically ongoing system maintenance and management costs that must be borne. In the hospital setting, costs vary widely. Nonetheless, purchasing a robust health information technology system, conducting training of personnel, integrating a new health information technology system into legacy computerized systems, and purchasing technical support services can cost millions of dollars for community hospital of average size.

Most experts estimate that the widespread adoption of health information technology will result in a substantial cost savings over time in our health care system. While providers must bear the full cost of acquiring these systems, a large part of these economic savings will accrue to health insurers and large integrated health care systems, rather than to physicians in office practices or smaller community hospitals.

Many physicians and community hospitals, community health centers and other provider organizations operate with small financial margins and have difficulty affording modern health information technology systems for use in these clinical settings.

Because of the current cost and segmented reimbursement, rates of adoption of modern health information technology in the United States are very low. Less than 20 percent of physicians in office practice and of hospitals currently use simple electronic health records.

In order to address the health information technology "adoption gap" in the United States, S. 1418 authorizes three grant programs that will carefully target financial support to health care providers and consortia for the purpose of facilitating the adoption of interoperable health information technology. The bill leaves to the discretion of the Secretary the allocation of the authorization among the three programs.

In addition, the greatest improvements in quality of health care and cost savings will be realized when all elements of the health care system are electronically connected and speak a common technical language—that is they are interoperable. For this reason, each grant program requires that each grant recipient acquire only qualified health information technology systems that are capable of

supporting common technical standards and full interoperability and reporting performance on quality measures adopted by the Federal Government under this legislation.

The first grant program will award grants, on a competitive basis, to health care providers to facilitate the purchase and enhance the utilization of qualified health information technology systems to improve the quality and efficiency of health care. Awards will be made by the Secretary of the Department of Health and Human Services. Grant recipients must provide matching funds equal to $1 for each $3 of Federal funds provided under the grant.

The bill defines health care providers as hospitals, skilled nursing facilities, home health entities, health care clinics, federally qualified health centers, group practices, pharmacists, pharmacies, laboratories, physicians, health facilities operated by or pursuant to a contract with the Indian Health Service, rural health clinics, and other entities determined appropriate by the Secretary.

Because the committee recognizes the importance of targeting scarce Federal resources where they are most needed, this grant program will give preference to providers that may be least likely to have the capital to acquire health information technology in the absence of a grant—those that are located in rural, frontier and other underserved areas. The committee also recognizes that while there are immediate improvements in quality of care and error reduction with the use of health information technology such as electronic health records, the full benefits of implementing such systems will only be realized when individual provider's systems are all interconnected and patient information will be available when and where it is needed. Thus, this grant program will also give preference to providers that will link, to the extent practicable, their health information system to local or regional health information systems.

In order to maximize the utility of health information technology systems acquired under this grant program in improving and measuring quality of care, grant recipients will be required to report their performance on a set of quality-of-care measures to be adopted by the Federal Government under this bill.

The second program will award grants on a competitive basis to States for the establishment of State programs that will offer loans to health care providers to facilitate the purchase and enhance the utilization of qualified health information technology. To be eligible to receive such a grant, States must establish a State loan fund and submit an application to the Secretary of the Department of Health and Human Services with a strategic plan that criteria for awarding loans to eligible entities. State loan programs will be required to stipulate that preference in awarding loans will be given to providers who will link, to the extent practicable, their health information system to local or regional health information systems. States will be required to match $1 dollar for every $1 of Federal funds provided under the grant. The Secretary may give preference to States that adopt value-based purchasing programs to improve health care quality.

To maximize the likelihood that scarce Federal resources will be spent on projects with the greatest likelihood of success, recipients of loans will also be required to consult with the Health Information Technology Resource Center—established in this bill—that

will provide technical assistance and develop best practices to support and accelerate efforts to adopt, implement, and use effectively interoperable health information technology.

To maximize the utility of health information technology systems acquired under this loan program in improving and measuring quality of care, loan recipients will be required to report their performance on a set of quality-of-care measures to be adopted by the Federal Government under this bill.

States may use grant funds to make loans directly to providers or may use funds to securitize additional loans or bonds, thereby augmenting the total amount of capital available in the program to loan to providers. In addition, State programs may accept voluntary contributions from private entities that may have a strong interest in expanding adoption of health information technology among health care providers in their State or local area. An incentive for private entities to contribute voluntarily to the loan program in their State is that programs may publicize the names of private entities that make contributions. The committee sees a positive marketing value associated with this public recognition of responsible corporate citizenship.

The third program allows the Secretary to award competitive grants to implement regional or local health information technology plans that improve healthcare quality and efficiency through the use of interoperable health information technology compliant with technology standards and the quality measurement system. To receive a grant, eligible entities must be comprised of a consortium of community stakeholders that demonstrate financial need, adopt policies that demonstrate a commitment to open and fair participation, and demonstrate a commitment to improving the quality of healthcare through the use of interoperable health information technology.

The committee finds that the development and implementation of regional or local health information technology plans is a critical strategy in the Nation's efforts to build a nationwide interoperable health information technology infrastructure. Community exchange of health information through regional or local health information technology plans compliant with standards will maximize the benefits that patients experience from system-wide use of health IT and minimize costly technology links and retrofitting that would be necessary if healthcare stakeholders adopt health IT independent of an interoperable regional or local health information technology plan.

However, the committee recognizes that there may be instances in which inclusion of all required stakeholders outlined may not be possible and the legislation provides the Secretary some flexibility in such cases. However, the committee believes that only applications that demonstrate the strongest commitment to a community-wide collaboration through the most extensive partnering feasible be provided funding.

The legislation provides for one non-renewable local or regional health information technology plan grant per entity. The Federal Government must lead the effort to develop and implement a nationwide interoperable health information technology infrastructure through the adoption, certification, and implementation of standards in conjunction with, and inextricably linked to, the adoption

and reporting of quality measures integrated into the technology infrastructure. While it is the intent of the committee that Federal resources provided through these non-renewable grants be used to jump-start local or regional health information technology plans that can demonstrate sustainability beyond the grant period, it is not the intention of the committee that these non-renewable grants be limited to a single year or that the Secretary's authority to negotiate the timeframe or grant amount be restricted.

The legislation authorizes $116 million in fiscal year 2006 and $141 million for fiscal year 2007 for the three grant sections. The bill leaves to the discretion of the Secretary the allocation of the authorization among the three programs. The committee is dedicated to fiscal responsibility.

Another barrier to widespread adoption of interoperable health information is cultural. The committee recognizes that many physicians and hospitals are hesitant to move from paper-based systems to electronic systems. Some physicians have been writing prescriptions by hand for many years and may resist changing to electronic prescribing for instance.

This committee believes that one way to address this cultural barrier to the widespread adoption of health information technology is to support teaching hospitals and continuing education programs that integrate health information technology in the clinical education of health care professionals. The committee believes that exposing students and residents to effective everyday uses of health IT will lead to a greater adoption by these students and residents when they graduate and begin practicing on their own. The bill authorizes the Secretary to award demonstration grants to health professions centers and academic health centers to integrate health IT into clinical education in community settings. To be eligible, grantees must submit a strategic plan and provide matching funds of at least $1 for every $2 of Federal funding. The Secretary is required to evaluate the program and disseminate the results, and to report annually to Congress. The legislation authorizes 5 million dollars for fiscal year 2007 for this section.

State laws and regulatory bodies determine the requirements for licensure of health professionals that seek to practice within their jurisdiction. The committee strongly believes that the licensure of health professionals should remain within the jurisdiction of States. Thirty-four [34] states have laws or regulations in place which speak to the treatment of patients remotely, usually through telemedicine. Yet most existing licensure requirements do not speak to the full range of issues presented through telemedicine and similar technologies. Therefore, this bill directs the Secretary to conduct a review of the licensure requirements of States and the related issues that licensure bodies confront as a nationwide interoperable electronic health information system is developed.

The bill also reauthorizes Telemedicine Incentive Grants through 2010. These grants were established to encourage state licensure bodies to address remote treatment issues.

This legislation directs the Secretary of Health and Human Services, in consultation with the Secretary of Defense, Secretary of Veterans Affairs, and the heads of other relevant Federal agencies to develop or adopt a quality measurement system that includes measures to assess the effectiveness, timeliness, patient self-man-

agement, patient centeredness, efficiency, and safety of care received by patients, as recommended by the Institute of Medicine. In developing the quality measurement system, the legislation requires the Secretary to give priority to measures with the greatest impact for improving quality and efficiency, measures that may be rapidly implemented, and measures that help consumers and patients make informed decisions about their care.

The Rand Institute reports that patients receive care that is appropriate to their condition only 55 percent of the time and best clinical practices take, on average, 17 years to reach the bedside. The committee finds that the development and adoption of a quality measurement system and its integration with the interoperable health information technology system under this legislation is a critical step in eradicating these deficiencies and improving the quality of health care that all Americans receive.

In developing and updating the quality measurement system, the Secretary shall enter an arrangement with a private entity to receive advice and recommendations with regard to the development and updating of the quality measurement system. The committee intends the development and updating of the quality measurement system to recognize those established measurement sets that have gone through a multi-stakeholder, open and accountable process and are currently in use by both the Secretary and the private sector, including the Health Plan Employer Data and Information Set and the Consumer Assessment of Health Plans. It is the intention of the committee to avoid the duplication of these established measures and expects that the Secretary will adopt these measure sets and additions to them.

The committee intends the widespread adoption and use of measures adopted through the development and updating of the quality measurement system. To that end, the legislation allows the Secretary to establish collaborative agreements with private entities to encourage the use of the measures adopted by the Secretary and to foster uniformity between measures utilized by the Federal Government and private entities to minimize administrative burden on healthcare providers.

The legislation also requires reporting of quality measures by entities receiving grants and loans and allows the Secretary to aggregate, analyze and disseminate quality data for the purposes of providing information to consumers, professionals, officials and researchers.

Because the committee believes that protecting the privacy and security of health information is the most important aspect of creating an interoperable health information infrastructure, the bill clarifies that the Health Insurance Portability and Accountability Act of 1996 privacy and security laws and regulations that apply to health information also apply to health information stored or transmitted in electronic format.

The bill also directs the Secretary to study reimbursement incentives for improving the quality of care at Federally qualified health centers and other sites where reimbursement is paid primarily on a cost basis, rather than through a prospective payment system.

The bill also amends the Public Health Service Act and directs the Secretary, acting through the Director of the Agency for Health Care Research and Quality, to develop a Health Information Tech-

nology Resource Center to provide technical assistance and develop best practices to support and accelerate the efforts of States and health care providers to adopt, implement, and use effectively health information technology that complies with the standards and quality measurement system adopted by the Federal Government. The committee believes it is important to provide a forum for the exchange of knowledge and experience, accelerate the transfer of lessons learned from existing public and private sector initiatives, and assemble, analyze, and widely disseminate evidence and experience related to the adoption, implementation, and effective use of interoperable health information technology. The legislation requires the Secretary to establish a health IT technical assistance toll-free telephone number or Internet site.

The Secretary has begun undertaking the activities outlined in this section of the legislation. It is the committee's intent not to require the duplication of Federal efforts with respect to the establishment of the Center.

The committee believes this legislation integrates technology and quality to create a seamless, efficient health care system for the 21st century.

This legislation will help facilitate the widespread adoption of electronic health records to ultimately result in fewer mistakes, lower costs, better care, and greater patient participation in their health and well being.

## V. COST ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
*Washington, DC, July 26, 2005.*

Hon. MIKE B. ENZI,
*Chairman, Committee on Health, Education, Labor, and Pensions, U.S. Senate, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 1418, the Wired for Health Care Quality Act.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Tom Bradley.

Sincerely,

ELIZABETH M. ROBINSON
(For Douglas Holtz-Eakin, Director).

Enclosure.

*S. 1418—Wired for Health Care Quality Act*

Summary: CBO estimates that implementing S. 1418 would cost $40 million in 2006 and $652 million over the 2006–2010 period, assuming appropriation of the necessary amounts. Enacting the bill would have no effect on direct spending or revenues.

On April 27, 2004, the President issued Executive Order 13335, which established within the Office of the Secretary of Health and Human Services (HHS) the position of National Health Information Technology Coordinator. The Secretary subsequently established the Office of the National Coordinator of Health Information Technology (ONCHIT) and the American Health Information Commu-

nity (AHIC) to support the adoption of health information technology. S. 1418 would amend the Public Health Service Act (PHSA) to codify the establishment and responsibilities of those entities. In addition, the bill would authorize appropriation of funding for grants to facilitate the widespread adoption of certain health information technology. S. 1418 would authorize the appropriation of $125 million in 2006, $155 million in 2007, and such sums as necessary for 2008 through 2010 for those activities.

S. 1418 also would require the Agency for Healthcare Research and Quality (AHRQ) to establish a Center for Best Practices to provide technical assistance to support the adoption of health information technology, and it would extend through 2010 authorization for a program to provide telemedicine grants.

S. 1418 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). Any costs to State, local or tribal governments as a result of participating in the grant programs would be incurred voluntarily.

Estimated cost to the Federal Government: The estimated cost of S. 1418 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

| | By fiscal year, in millions of dollars— | | | | | |
|---|---|---|---|---|---|---|
| | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
| SPENDING SUBJECT TO APPROPRIATION | | | | | | |
| Spending under Current Law: | | | | | | |
| Estimated Budget Authority[1] | 20 | 0 | 0 | 0 | 0 | 0 |
| Estimated Outlays | 4 | 14 | 2 | 0 | 0 | 0 |
| Proposed Changes: | | | | | | |
| Estimated Authorization Level | 0 | 133 | 163 | 166 | 169 | 172 |
| Estimated Outlays | 0 | 40 | 125 | 156 | 164 | 167 |
| Spending under S. 1418: | | | | | | |
| Estimated Authorization Level[1] | 20 | 133 | 163 | 166 | 169 | 172 |
| Estimated Outlays | 4 | 54 | 127 | 156 | 164 | 167 |

[1] The 2005 level is CBO's estimate of the funding for the activities of the Office of the National Coordinator of Health Information Technology and the American Health Information Community, including funds reprogrammed by the Secretary of Health and Human Services from other activities.

Basis of estimate: S. 1418 would amend the Public Health Service act to add title 29— which would deal with health information technology and quality—and to create a Center for Best Practices and extend authorization for a program to provide telemedicine grants. For this estimate, CBO assumes that S. 1418 will be enacted near the end of fiscal year 2005, that the necessary amounts will be appropriated each year, and that outlays will follow historical patterns for similar activities of the Department of Health and Human Services. CBO estimates that implementing those provisions would cost $40 million in 2006 and $652 over the 2006–2010 period.

*Health information technology and quality*

The National Coordinator of Health Information Technology serves as the senior advisor to the Secretary of HHS and the President on all health information technology programs and initiatives, and is responsible for:

- Developing and maintaining a strategic plan to guide the nationwide implementation of electronic health records in both the public and private health care sectors;

- Coordinating spending by federal agencies for health information technology programs and initiatives; and
- Coordinating outreach activities to private industry and serving as the catalyst for change in the health care industry.

In June 2005, the Secretary announced the creation of the American Health Information Community a public-private collaboration to provide a forum for public and private interests to recommend specific actions that will accelerate the widespread adoption of electronic records and other health information technology. Based on information provided by the Department of Health and Human Services, CBO estimates that $20 million is available in 2005 for the activities of ONCHIT and AHIC ($3 million from funds appropriated to the Secretary and $17 million from funds reprogrammed from other activities).

S. 1418 would add title 29 to the Public Health Service Act to codify the establishment and responsibilities of ONCHIT and AHIC. (It would change the name of the latter organization to the American Health Information Collaborative). The bill would establish several grant programs to promote the adoption of health information technology.

For activities under title 29, S. 1418 would authorize the appropriation of $125 million in 2006, $155 million in 2007, and such sums as necessary in 2008 through 2010. Of the amounts specified in 2006 and 2007, $5 million would be for ONCHIT in each year; $4 million a year would be for AHIC; and the remaining $116 million in 2006 and $146 million in 2007 would be for the grant programs.

The bill would establish three grant programs—for health care providers, states, and to implement regional or local plans for the exchange of health information—to facilitate the adoption of health information technology and a fourth grant program to develop academic curricula integrating health information technology systems into the clinical education of health professionals.

The bill would limit eligibility for the grants to health care providers to providers that demonstrate significant financial need. Those providers would be required to provide $1 of matching funds for every $3 of Federal grant funds, and they could use the funds to purchase and enhance the utilization of health information technology and for training personnel in the use of the technology.

States would be eligible for grants that would fund the establishment of State programs for loans to health care providers to facilitate the purchase and use of health information technology. States would have to provide $1 of matching funds for every $1 of Federal grant funds.

The grants to implement regional or local plans for the exchange of health information would require $1 of matching funds for every $2 of Federal grant funds. The President's budget request for fiscal year 2006 included $50 million for a similar program. That program, which is in the request-for-proposal stage, would provide funding and oversight through contracts, rather than grants.

*Other provisions*

In addition to adding title 29 to the Public Health Service Act, S. 1418 would amend that act to establish a Center for Best Practices to provide technical assistance to support the adoption of

health information technology, and it would extend through 2010 authorization for a program to provide telemedicine grants. The Center would be administered by AHRQ, and the telemedicine grants would be administered by the Health Resources and Services Administration (HRSA). Based on information provided by the Department of Health and Human Services, CBO estimates that implementing those provisions would require additional appropriations in 2006 through 2010 of $3 million a year for the Center and $5 million a year for HRSA.

Intergovernmental and private-sector impact: S. 1418 contains no intergovernmental or private-sector mandates as defined in UMRA. The bill would not require any action on the part of State, local, or tribal governments, but it would provide grant money to public health entities that wish to implement health record transfer systems. Therefore, CBO assumes that any costs to those entities as a result of participating in the grant programs would be incurred voluntarily.

Estimate prepared by: Federal Costs: Tom Bradley. Impact on State, Local, and Tribal Governments: Leo Lex and Ian Rudge. Impact on the Private Sector: Peter Richmond.

Estimate approved by: Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

## VI. Application of Law to the Legislative Branch

The committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

## VII. Regulatory Impact Statement

Pursuant to the requirements of paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the committee has determined that the bill will not have a significant regulatory impact.

## VIII. Section-by-Section Analysis

*Section 1. Short title*

Wired for Health Care Quality Act

*Section 2. Improving health care quality, safety, and efficiency*

Amends the Public Health Service Act by adding at the end: "Title XXIX—Health Information Technology and Quality"

*Section 2901. Definitions*

"Healthcare Provider," "Health Information," "Health Insurance Plan," "Laboratory," "Pharmacist," "Qualified Health Information Technology," and "State"

*Section 2902. Office of the National Coordinator for Health Information Technology*

Establishes the Office of the National Coordinator within the Office of the Secretary for Health and Human Services

*Section 2903. American Health Information Collaborative*

The Secretary of HHS shall establish and serve as the Chairman of the FACA compliant, public-private American Health Information Collaborative. The Collaborative shall be comprised of members representing the Federal Government and private entities. The Collaborative shall—

Serve as a forum for the participation of a broad range of stakeholders to provide input on achieving interoperability of health information technology;

Recommend to the Secretary uniform national standard and policies for adoption by the Federal Government and voluntary adoption by private entities to support the widespread adoption of health information technology; and

Review existing standards (including content, communication, and security standards), identify deficiencies, omissions, duplication and overlap in existing standards and recommend new standards and necessary modifications for the electronic exchange of health information for adoption by the Federal Government and voluntary adoption by private entities to support the widespread adoption of health information technology.

Upon receipt of recommendations from the Collaborative, the Secretary of Health and Human Services, the Secretary of Veterans Affairs, and the Secretary of Defense, in collaboration with representatives of other relevant Federal agencies, shall jointly review and the Secretary shall provide for the adoption by the Federal Government of any standard or standards contained in such recommendation. One year after enactment, no Federal agency shall expend Federal funds for the purchase of health information technology that is not compliant with the applicable standards adopted by the Federal Government.

*Section 2904. Implementation and certification of standards*

The Secretary, based on recommendations of the Collaborative shall develop criteria to—

Ensure uniform and consistent implementation of any standards for the electronic exchange of health information; and

Ensure and certify that hardware, software, and support services that claim to be in compliance with any standard have established and maintain such compliance.

The Secretary may recognize a private entity to assist in the implementation and certification of the standards adopted by the Federal Government, and the Secretary may accept recommendations on the development of criteria from a Federal agency or a private entity.

*Section 2905. Grants to facilitate the widespread adoption of interoperable health information technology*

The Secretary may award competitive, matching grants to eligible entities to facilitate the widespread adoption of health information technology;

The Secretary may award competitive, matching grants to states interested in establishing state programs for loans to healthcare providers for purchasing qualified health information technology. To qualify for this federal "seed money" for their own loan programs, States must match each dollar of federal funds with a dollar

of state contributions. States must ensure that providers receiving such loans are purchasing information technology that is consistent with standards adopted by the Federal Government; and

There is authorized to be appropriated $125 million in FY 2006 and $155 million in FY 2007 and such sums as necessary from FY 2008 through 2010.

*Section 2906. Demonstration program to integrate information technology into clinical education*

The Secretary may award competitive grants to carry out demonstration projects to develop academic curricula integrating qualified health information technology systems in the clinical education of health professionals.

*Section 2907. Licensure and the electronic exchange of health information*

Instructs the Secretary to study state laws for the licensure, registration, and certification of medical professionals and, within one year, issue a report with recommendations for the harmonization of such laws. Reauthorizes, through FY2010, grants to state licensing boards to develop policies that reduce the statutory and regulatory barriers to telemedicine (PHS Act Section 330L).

*Section 2908. Quality measurement system*

The bill directs the Secretary to develop and periodically update a quality measurement system for assessing the quality of care patients receive. The legislation also requires the Secretary, in implementing such system, to take into account the recommendations of public-private entities that involve health care representatives and others interested in the quality of care. The bill requires the Secretary, by July 1, 2006, to have in place an arrangement with a private nonprofit entity to provide advice and recommendations on developing and updating the quality measurement system, and specifies the membership of such entity.

*Section 2909. Ensuring privacy and security*

The HIPAA and Social Security statutes and regulations regarding privacy, confidentiality, and security of health information shall apply to everything in this act.

*Section 2910. Study of reimbursement incentives*

The Secretary shall carry out, or contract with a private entity to carry out, a study that examines methods to create efficient reimbursement incentives for improving healthcare quality in community Federally qualified health centers, rural health clinics, and free clinics.

*Section 3. Health information technology resource center*

Amends the Public Health Service Act and establishes a Health Information Technology Resource Center to provide technical assistance and develop best practices to support and accelerate efforts to adopt, implement, and effectively use interoperable health information technology.

## IX. CHANGES IN EXISTING LAW

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

## PUBLIC HEALTH SERVICE ACT

* * * * * * *

**SEC. 330L. TELEMEDICINE; INCENTIVE GRANTS REGARDING COORDINATION AMONG STATES.**

(a) IN GENERAL.— * * *

(b) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out subsection (a), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years [2002 through 2006] *2006 through 2010*.

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**SEC. 914. INFORMATION SYSTEMS FOR HEALTH CARE IMPROVEMENT.**

(a) IN GENERAL.— * * *

* * * * * * *

(c) FACILITATING PUBLIC ACCESS TO INFORMATION.— * * *

* * * * * * *

*(d) HEALTH INFORMATION TECHNOLOGY RESOURCE CENTER.—*

*(a) IN GENERAL.—The Secretary, acting through the Director, shall develop a Health Information Technology Resource Center to provide technical assistance and develop best practices to support and accelerate efforts to adopt, implement, and effectively use interoperable health information technology in compliance with section 2903 and 2908.*

*(2) HEALTH INFORMATION TECHNOLOGY RESOURCE CENTER.—*

*(A) IN GENERAL.—The Center shall support activities to meet goals, including—*

*(i) providing for the widespread adoption of interoperable health information technology;*

*(ii) providing for the establishment of regional and local health information networks to facilitate the development of interoperability across health care settings and improve the quality of health care;*

*(iii) the development of solutions to barriers to the exchange of electronic health information; or*

*(iv) other activities identified by the States, local or regional health information networks, or health care stakeholders as a focus for developing and sharing best practices.*

*(B) PURPOSES.—The purpose of the Center is to—*

*(i) provide a forum for the exchange of knowledge and experience;*

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

*(iii) assemble, analyze, and widely disseminate evidence and experience related to the adoption, implementation, and effective use of interoperable health information technology.*

*(C) SUPPORT FOR ACTIVITIES.—To provide support for the activities of the Center, the Director shall modify the requirements, if necessary, that apply to the National Resource Center for Health Information Technology to provide the necessary infrastructure to support the duties and activities of the Center and facilitate information exchange across the public and private sectors.*

*(3) TECHNICAL ASSISTANCE TELEPHONE NUMBER OR WEBSITE.—The Secretary shall establish a toll-free telephone number or Internet website to provide health care providers and patients with a single point of contact to—*

*(A) learn about Federal grants and technical assistance services related to interoperable health information technology;*

*(B) learn about qualified health information technology and the quality measurement system adopted by the Federal Government under sections 2903 and 2908;*

*(C) learn about regional and local health information networks for assistance with health information technology; and*

*(D) disseminate additional information determined by the Secretary.*

*(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to require the duplication of Federal efforts with respect to the establishment of the Center, regardless of whether such efforts were carried out prior to or after the enactment of this subsection.*

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# *TITLE XXVIII—NATIONAL PREPAREDNESS FOR BIOTERRORISM AND OTHER PUBLIC HEALTH EMERGENCIES*

## *Subtitle A—National Preparedness and Response Planning, Coordinating, and Reporting*

***SEC. 2801. NATIONAL PREPAREDNESS PLAN.***

*(a) IN GENERAL.—*

*(1) PREPAREDNESS AND RESPONSE REGARDING PUBLIC HEALTH EMERGENCIES.— * * **

* * * * * * *

## *Subtitle B—Emergency Preparedness and Response*

***SEC. 2811. COORDINATION OF PREPAREDNESS FOR AND RESPONSE TO BIOTERRORISM AND OTHER PUBLIC HEALTH EMERGENCIES.***

*(a) ASSISTANT SECRETARY FOR PUBLIC HEALTH EMERGENCY PREPAREDNESS.—*

*(1) IN GENERAL.— * * **

* * * * * * *

# *TITLE XXIX—HEALTH INFORMATION TECHNOLOGY AND QUALITY*

***SEC. 2901. DEFINITIONS.***

*In this title:*

*(1) HEALTH CARE PROVIDER.—The term "health care provider" means a hospital, skilled nursing facility, home health entity, health care clinic, federally qualified health center, group practice (as defined in section 1877(h)(4) of the Social Security Act), a pharmacist, a pharmacy, a laboratory, a physician (as defined in section 1861(r) of the Social Security Act), a health facility operated by or pursuant to a contract with the Indian Health Service, a rural health clinic, and any other category of facility or clinician determined appropriate by the Secretary.*

*(2) HEALTH INFORMATION.—The term "health information" has the meaning given such term in section 1171(4) of the Social Security Act.*

*(3) HEALTH INSURANCE PLAN.—The term "health insurance plan" means—*

*(A) a health insurance issuer (as defined in section 2791(b)(2));*

*(B) a group health plan (as defined in section 2791(a)(1)); and*

*(C) a health maintenance organization (as defined in section 2791(b)(3)).*

*(4) LABORATORY.—The term "laboratory" has the meaning given that term in section 353.*

*(5) PHARMACIST.—The term "pharmacist" has the meaning given that term in section 804 of the Federal Food, Drug, and Cosmetic Act.*

*(6) QUALIFIED HEALTH INFORMATION TECHNOLOGY.—The term "qualified health information technology" means a computerized system (including hardware and software) that—*

*(A) protects the privacy and security of health information;*

*(B) maintains and provides permitted access to health information in an electronic format;*

*(C) incorporates decision support to reduce medical errors and enhance health care quality;*

*(D) complies with the standards adopted by the Federal Government under section 2903; and*

*(E) allows for the reporting of quality measures under section 2908.*

*(7) STATE.—The term "State" means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.*

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

*(a) OFFICE OF NATIONAL HEALTH INFORMATION TECHNOLOGY.—There is established within the Office of the Secretary an Office of*

*the National Coordinator of Health Information Technology (referred to in this section as the "Office"). The Office shall be headed by a National Coordinator who shall be appointed by the President, in consultation with the Secretary, and shall report directly to the Secretary.*

*(b) PURPOSE.—It shall be the purpose of the Office to coordinate and oversee programs and activities to develop a nationwide interoperable health information technology infrastructure that—*

*(1) ensures that patients' health information is secure and protected;*

*(2) improves health care quality, reduces medical errors, and advances the delivery of patient-centered medical care;*

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

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

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

*(6) improves the coordination of care and information among hospitals, laboratories, physician offices, and other entities through an effective infrastructure for the secure and authorized exchange of health care information;*

*(7) improves public health reporting and facilitates the early identification and rapid response to public health threats and emergencies, including bioterror events and infectious disease outbreaks;*

*(8) facilitates health research; and*

*(9) promotes prevention of chronic diseases.*

*(c) DUTIES OF THE NATIONAL COORDINATOR.—The National Coordinator shall—*

*(1) serve as a member of the public-private American Health Information Collaborative established under section 2903;*

*(2) serve as the principal advisor to the Secretary concerning the development, application, and use of health information technology, and coordinate and oversee the health information technology programs of the Department;*

*(3) facilitate the adoption of a nationwide, interoperable system for the electronic exchange of health information;*

*(4) ensure the adoption and implementation of standards for the electronic exchange of health information to reduce cost and improve health care quality;*

*(5) ensure that health information technology policy and programs of the Department are coordinated with those of relevant executive branch agencies (including Federal commissions) with a goal of avoiding duplication of efforts and of helping to ensure that each agency undertakes health information technology activities primarily within the areas of its greatest expertise and technical capability;*

*(6) to the extent permitted by law, coordinate outreach and consultation by the relevant executive branch agencies (including Federal commissions) with public and private parties of interest, including consumers, payers, employers, hospitals and other health care providers, physicians, community health centers, laboratories, vendors and other stakeholders;*

*(7) advise the President regarding specific Federal health information technology programs; and*

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

*(d) DETAIL OF FEDERAL EMPLOYEES.—*

*(1) IN GENERAL.—Upon the request of the National Coordinator, the head of any Federal agency is authorized to detail, with or without reimbursement from the Office, any of the personnel of such agency to the Office to assist it in carrying out its duties under this section.*

*(2) EFFECT OF DETAIL.—Any detail of personnel under paragraph (1) shall—*

*(A) not interrupt or otherwise affect the civil service status or privileges of the Federal employee; and*

*(B) be in addition to any other staff of the Department employed by the National Coordinator.*

*(3) ACCEPTANCE OF DETAILEES.—Notwithstanding any other provision of law, the Office may accept detailed personnel from other Federal agencies without regard to whether the agency described under paragraph (1) is reimbursed.*

*(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require the duplication of Federal efforts with respect to the establishment of the Office, regardless of whether such efforts were carried out prior to or after the enactment of this title.*

*(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $5,000,000 for fiscal year 2006, $5,000,000 for fiscal year 2007, and such sums as may be necessary for each of fiscal years 2008 through 2010.*

***SEC. 2903. AMERICAN HEALTH INFORMATION COLLABORATIVE.***

*(a) PURPOSE.—The Secretary shall establish the public-private American Health Information Collaborative (referred to in this section as the "Collaborative") to—*

*(1) advise the Secretary and recommend specific actions to achieve a nationwide interoperable health information technology infrastructure;*

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

*(3) recommend standards (including content, communication, and security standards) for the electronic exchange of health information (including for the reporting of quality data under section 2908) for adoption by the Federal Government and voluntary adoption by private entities.*

*(b) COMPOSITION.—*

*(1) IN GENERAL.—The Collaborative shall be composed of—*

*(A) the Secretary, who shall serve as the chairperson of the Collaborative;*

*(B) the Secretary of Defense, or his or her designee;*

*(C) the Secretary of Veterans Affairs, or his or her designee;*

*(D) the Secretary of Commerce, or his or her designee;*

*(E) the National Coordinator for Health Information Technology;*

*(F) representatives of other relevant Federal agencies, as determined appropriate by the Secretary; and*

*(G) representatives from each of the following categories to be appointed by the Secretary from nominations submitted by the public—*

*(i) consumer and patient organizations;*

*(ii) experts in health information privacy and security;*

*(iii) health care providers;*

*(iv) health insurance plans or other third party payors;*

*(v) standards development organizations;*

*(vi) information technology vendors;*

*(vii) purchasers or employers; and*

*(viii) State or local government agencies or Indian tribe or tribal organizations.*

*(2) CONSIDERATIONS.—In appointing members under paragraph (1)(G), the Secretary shall select individuals with expertise in—*

*(A) health information privacy;*

*(B) health information security;*

*(C) health care quality and patient safety, including those individuals with experience in utilizing health information technology to improve health care quality and patient safety;*

*(D) data exchange; and*

*(E) developing health information technology standards and new health information technology.*

*(3) PARTICIPATION.—Membership and procedures of the Collaborative shall ensure a balance among various sectors of the healthcare system so that no single sector unduly influences the recommendations of the Collaborative.*

*(4) TERMS.—Members appointed under paragraph (1)(G) shall serve for 2 year terms, except that any member appointed to fill a vacancy for an unexpired term shall be appointed for the remainder of such term. A member may serve for not to exceed 180 days after the expiration of such member's term or until a successor has been appointed.*

*(c) RECOMMENDATIONS AND POLICIES.— Not later than 1 year after the date of enactment of this title, and annually thereafter, the Collaborative shall recommend to the Secretary uniform national policies for adoption by the Federal Government and voluntary adoption by private entities to support the widespread adoption of health information technology, including—*

*(1) protection of health information through privacy and security practices;*

*(2) measures to prevent unauthorized access to health information;*

*(3) methods to facilitate secure patient access to health information;*

*(4) fostering the public understanding of health information technology;*

*(5) the ongoing harmonization of industry-wide health information technology standards;*

*(6) recommendations for a nationwide interoperable health information technology infrastructure;*

*(7) the identification and prioritization of specific use cases for which health information technology is valuable, beneficial, and feasible;*

*(8) recommendations for the establishment of an entity to ensure the continuation of the functions of the Collaborative; and*

*(9) other policies (including recommendations for incorporating health information technology into the provision of care and the organization of the health care workplace) determined to be necessary by the Collaborative.*

*(d) STANDARDS.—*

*(1) EXISTING STANDARDS.—The standards adopted by the Consolidated Health Informatics Initiative shall be deemed to have been recommended by the Collaborative under this section.*

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

*(A) review existing standards (including content, communication, and security standards) for the electronic exchange of health information, including such standards adopted by the Secretary under paragraph (2)(A);*

*(B) identify deficiencies and omissions in such existing standards; and*

*(C) identify duplication and overlap in such existing standards;*

*and recommend new standards and modifications to such existing standards as necessary.*

*(3) ONGOING REVIEW.—Beginning 1 year after the date of enactment of this title, and annually thereafter, the Collaborative shall—*

*(A) review existing standards (including content, communication, and security standards) for the electronic exchange of health information, including such standards adopted by the Secretary under paragraph (2)(A);*

*(B) identify deficiencies and omissions in such existing standards; and*

*(C) identify duplication and overlap in such existing standards;*

*and recommend new standards and modifications to such existing standards as necessary.*

*(4) LIMITATION.—The standards and timeframe for adoption described in this section shall be consistent with any standards developed pursuant to the Health Insurance Portability and Accountability Act of 1996.*

*(e) FEDERAL ACTION.—Not later than 60 days after the issuance of a recommendation from the Collaborative under subsection (d)(2), the Secretary of Health and Human Services, the Secretary of Veterans Affairs, and the Secretary of Defense, in collaboration with representatives of other relevant Federal agencies, as determined appropriate by the Secretary, shall jointly review such recommendations. The Secretary shall provide for the adoption by the Federal Government of any standard or standards contained in such recommendation.*

*(f) COORDINATION OF FEDERAL SPENDING.—Not later than 1 year after the adoption by the Federal Government of a recommendation as provided for in subsection (e), and in compliance with chapter 113 of title 40, United States Code, no Federal agency shall expend*

*Federal funds for the purchase of any form of health information technology or health information technology system for clinical care or for the electronic retrieval, storage, or exchange of health information that is not consistent with applicable standards adopted by the Federal Government under subsection (e).*

*(g) COORDINATION OF FEDERAL DATA COLLECTION.—Not later than 3 years after the adoption by the Federal Government of a recommendation as provided for in subsection (e), all Federal agencies collecting health data for the purposes of quality reporting, surveillance, epidemiology, adverse event reporting, research, or for other purposes determined appropriate by the Secretary, shall comply with standards adopted under subsection (e).*

*(h) VOLUNTARY ADOPTION.—*

*(1) IN GENERAL.—Any standards adopted by the Federal Government under subsection (e) shall be voluntary with respect to private entities.*

*(2) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require that a private entity that enters into a contract with the Federal Government adopt the standards adopted by the Federal Government under section 2903 with respect to activities not related to the contract.*

*(3) LIMITATION.—Private entities that enter into a contract with the Federal Government shall adopt the standards adopted by the Federal Government under section 2903 for the purpose of activities under such Federal contract.*

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

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

*(2) describes barriers to the adoption of such a nationwide system;*

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

*(4) contains a plan and progress toward the establishment of an entity to ensure the continuation of the functions of the Collaborative.*

*(j) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the Collaborative, except that the term provided for under section 14(a)(2) shall be 5 years.*

*(k) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require the duplication of Federal efforts with respect to the establishment of the Collaborative, regardless of whether such efforts were carried out prior to or after the enactment of this title.*

*(l) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $4,000,000 for fiscal year 2006, $4,000,000 for fiscal year 2007, and such sums as may be necessary for each of fiscal years 2008 through 2010.*

***SEC. 2904. IMPLEMENTATION AND CERTIFICATION OF HEALTH INFORMATION STANDARDS.***

*(a) IMPLEMENTATION.—*

*(1) IN GENERAL.—The Secretary, based upon the recommendations of the Collaborative, shall develop criteria to ensure uniform and consistent implementation of any standards for the electronic exchange of health information voluntarily adopted by private entities in technical conformance with such standards adopted under this title.*

*(2) IMPLEMENTATION ASSISTANCE.—The Secretary may recognize a private entity or entities to assist private entities in the implementation of the standards adopted under this title using the criteria developed by the Secretary under this section.*

*(b) CERTIFICATION.—*

*(1) IN GENERAL.—The Secretary, based upon the recommendations of the Collaborative, shall develop criteria to ensure and certify that hardware and software that claim to be in compliance with any standard for the electronic exchange of health information adopted under this title have established and maintained such compliance in technical conformance with such standards.*

*(2) CERTIFICATION ASSISTANCE.—The Secretary may recognize a private entity or entities to assist in the certification described under paragraph (1) using the criteria developed by the Secretary under this section.*

*(c) DELEGATION AUTHORITY.—The Secretary, through consultation with the Collaborative, may accept recommendations on the development of the criteria under subsections (a) and (b) from a Federal agency or private entity.*

***SEC. 2905. GRANTS TO FACILITATE THE WIDESPREAD ADOPTION OF INTEROPERABLE HEALTH INFORMATION TECHNOLOGY.***

*(a) COMPETITIVE GRANTS TO FACILITATE THE WIDESPREAD ADOPTION OF HEALTH INFORMATION TECHNOLOGY.—*

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

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

*(A) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;*

*(B) submit to the Secretary a strategic plan for the implementation of data sharing and interoperability measures;*

*(C) be a—*

*(i) not for profit hospital;*

*(ii) individual or group practice; or*

*(iii) another health care provider not described in clause (i) or (ii);*

*(D) adopt the standards adopted by the Federal Government under section 2903;*

*(E) implement the measurement system adopted under section 2908 and report to the Secretary on such measures;*

*(F) demonstrate significant financial need; and*

*(G) provide matching funds in accordance with paragraph (4).*

*(3) USE OF FUNDS.—Amounts received under a grant under this subsection shall be used to facilitate the purchase and en-*

*hance the utilization of qualified health information technology systems.*

*(4) MATCHING REQUIREMENT.—To be eligible for a grant under this subsection an entity shall contribute non-Federal contributions to the costs of carrying out the activities for which the grant is awarded in an amount equal to $1 for each $3 of Federal funds provided under the grant.*

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

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

*(B) eligible entities that will link, to the extent practicable, the qualified health information system to local or regional health information plan or plans; and*

*(C) with respect to an entity described in subsection (a)(2)(C)(iii), a nonprofit health care provider.*

*(b) COMPETITIVE GRANTS TO STATES FOR THE DEVELOPMENT OF STATE LOAN PROGRAMS TO FACILITATE THE WIDESPREAD ADOPTION OF HEALTH INFORMATION TECHNOLOGY.—*

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

*(2) ESTABLISHMENT OF FUND.—To be eligible to receive a competitive grant under this subsection, a State shall establish a qualified health information technology loan fund (referred to in this subsection as a "State loan fund") and comply with the other requirements contained in this section. A grant to a State under this subsection shall be deposited in the State loan fund established by the State. No funds authorized by other provisions of this title to be used for other purposes specified in this title shall be deposited in any State loan fund.*

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

*(A) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;*

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

*(C) establish a qualified health information technology loan fund in accordance with paragraph (2);*

*(D) require that health care providers receiving such loans—*

*(i) link, to the extent practicable, the qualified health information system to a local or regional health information network; and*

*(ii) consult with the Health Information Technology Resource Center established in section 914(d) to access the knowledge and experience of existing initiatives regarding the successful implementation and effective use of health information technology;*

*(E) require that health care providers receiving such loans adopt the standards adopted by the Federal Government under section 2903;*

*(F) require that health care providers receiving such loans implement the measurement system adopted under section 2908 and report to the Secretary on such measures; and*

*(G) provide matching funds in accordance with paragraph (8).*

*(4) STRATEGIC PLAN.—*

*(A) IN GENERAL.—A State that receives a grant under this subsection shall annually prepare a strategic plan that identifies the intended uses of amounts available to the State loan fund of the State.*

*(B) CONTENTS.—A strategic plan under subparagraph (A) shall include—*

*(i) a list of the projects to be assisted through the State loan fund in the first fiscal year that begins after the date on which the plan is submitted;*

*(ii) a description of the criteria and methods established for the distribution of funds from the State loan fund; and*

*(iii) a description of the financial status of the State loan fund and the short-term and long-term goals of the State loan fund.*

*(5) USE OF FUNDS.—*

*(A) IN GENERAL.—Amounts deposited in a State loan fund, including loan repayments and interest earned on such amounts, shall be used only for awarding loans or loan guarantees, or as a source of reserve and security for leveraged loans, the proceeds of which are deposited in the State loan fund established under paragraph (1). Loans under this section may be used by a health care provider to facilitate the purchase and enhance the utilization of qualified health information technology and training of personnel in the use of such technology.*

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

*(i) for the purchase or other acquisition of any health information technology system that is not a qualified health information technology system;*

*(ii) to conduct activities for which Federal funds are expended under this title, or the amendments made by the Wired for Health Care Quality Act; or*

*(iii) for any purpose other than making loans to eligible entities under this section.*

*(6) TYPES OF ASSISTANCE.—Except as otherwise limited by applicable State law, amounts deposited into a State loan fund under this subsection may only be used for the following:*

*(A) To award loans that comply with the following:*

*(i) The interest rate for each loan shall be less than or equal to the market interest rate.*

*(ii) The principal and interest payments on each loan shall commence not later than 1 year after the loan was awarded, and each loan shall be fully amortized not later than 10 years after the date of the loan.*

*(iii) The State loan fund shall be credited with all payments of principal and interest on each loan awarded from the fund.*

*(B) To guarantee, or purchase insurance for, a local obligation (all of the proceeds of which finance a project eligible for assistance under this subsection) if the guarantee or purchase would improve credit market access or reduce the interest rate applicable to the obligation involved.*

*(C) As a source of revenue or security for the payment of principal and interest on revenue or general obligation bonds issued by the State if the proceeds of the sale of the bonds will be deposited into the State loan fund.*

*(D) To earn interest on the amounts deposited into the State loan fund.*

*(7) ADMINISTRATION OF STATE LOAN FUNDS.—*

*(A) COMBINED FINANCIAL ADMINISTRATION.—A State may (as a convenience and to avoid unnecessary administrative costs) combine, in accordance with State law, the financial administration of a State loan fund established under this subsection with the financial administration of any other revolving fund established by the State if otherwise not prohibited by the law under which the State loan fund was established.*

*(B) COST OF ADMINISTERING FUND.—Each State may annually use not to exceed 4 percent of the funds provided to the State under a grant under this subsection to pay the reasonable costs of the administration of the programs under this section, including the recovery of reasonable costs expended to establish a State loan fund which are incurred after the date of enactment of this title.*

*(C) GUIDANCE AND REGULATIONS.—The Secretary shall publish guidance and promulgate regulations as may be necessary to carry out the provisions of this subsection, including—*

*"(i) provisions to ensure that each State commits and expends funds allotted to the State under this subsection as efficiently as possible in accordance with this title and applicable State laws; and*

*"(ii) guidance to prevent waste, fraud, and abuse.*

*"(D) PRIVATE SECTOR CONTRIBUTIONS.—*

*"(i) IN GENERAL.—A State loan fund established under this subsection may accept contributions from private sector entities, except that such entities may not specify the recipient or recipients of any loan issued under this subsection.*

*"(ii) AVAILABILITY OF INFORMATION.—A State shall make publicly available the identity of, and amount contributed by, any private sector entity under clause (i) and may issue letters of commendation or make other awards (that have no financial value) to any such entity.*

*"(8) MATCHING REQUIREMENTS.—*

*"(A) IN GENERAL.—The Secretary may not make a grant under paragraph (1) to a State unless the State agrees to make available (directly or through donations from public*

*or private entities) non-Federal contributions in cash toward the costs of the State program to be implemented under the grant in an amount equal to not less than $1 for each $1 of Federal funds provided under the grant.*

*(B) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.—In determining the amount of non-Federal contributions that a State has provided pursuant to subparagraph (A), the Secretary may not include any amounts provided to the State by the Federal Government.*

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

*(10) REPORTS.—The Secretary shall annually submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate, and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives, a report summarizing the reports received by the Secretary from each State that receives a grant under this subsection.*

*(c) COMPETITIVE GRANTS FOR THE IMPLEMENTATION OF REGIONAL OR LOCAL HEALTH INFORMATION TECHNOLOGY PLANS.—*

*(1) IN GENERAL.—The Secretary may award competitive grants to eligible entities to implement regional or local health information plans to improve health care quality and efficiency through the electronic exchange of health information pursuant to the standards, protocols, and other requirements adopted by the Secretary under sections 2903 and 2908.*

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

*(A) demonstrate financial need to the Secretary;*

*(B) demonstrate that one of its principal missions or purposes is to use information technology to improve health care quality and efficiency;*

*(C) adopt bylaws, memoranda of understanding, or other charter documents that demonstrate that the governance structure and decisionmaking processes of such entity allow for participation on an ongoing basis by multiple stakeholders within a community, including—*

*(i) physicians (as defined in section 1861(r) of the Social Security Act), including physicians that provide services to low income and underserved populations;*

*(ii) hospitals (including hospitals that provide services to low income and underserved populations);*

*(iii) pharmacists or pharmacies;*

*(iv) health insurance plans;*

*(v) health centers (as defined in section 330(b)) and Federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act);*

*(vi) rural health clinics (as defined in section 1861(aa) of the Social Security Act);*

*(vii) patient or consumer organizations;*

*(viii) employers; and*

*(ix) any other health care providers or other entities, as determined appropriate by the Secretary;*

*(D) demonstrate the participation, to the extent practicable, of stakeholders in the electronic exchange of health information within the local or regional plan pursuant to paragraph (2)(C);*

*(E) adopt nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory participation in the health information plan by all stakeholders;*

*(F) adopt the standards adopted by the Secretary under section 2903;*

*(G) require that health care providers receiving such grants implement the measurement system adopted under section 2908 and report to the Secretary on such measures;*

*(H) facilitate the electronic exchange of health information within the local or regional area and among local and regional areas;*

*(I) prepare and submit to the Secretary an application in accordance with paragraph (3); and*

*(J) agree to provide matching funds in accordance with paragraph (5).*

*(3) APPLICATION.—*

*(A) IN GENERAL.—To be eligible to receive a grant under paragraph (1), an entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.*

*(B) REQUIRED INFORMATION.—At a minimum, an application submitted under this paragraph shall include—*

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

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

*(iii) a strategy that includes initiatives to improve health care quality and efficiency, including the use and reporting of health care quality measures adopted under section 2908;*

*(iv) a plan that describes provisions to encourage the implementation of the electronic exchange of health information by all physicians, including single physician practices and small physician groups participating in the health information plan;*

*(v) a plan to ensure the privacy and security of personal health information that is consistent with Federal and State law;*

*(vi) a governance plan that defines the manner in which the stakeholders shall jointly make policy and operational decisions on an ongoing basis; and*

*(vii) a financial or business plan that describes—*

*(I) the sustainability of the plan;*

*(II) the financial costs and benefits of the plan; and*

*(III) the entities to which such costs and benefits will accrue; and*

*(viii) if the case of an applicant entity that is unable to demonstrate the participation of all stakeholders pursuant to paragraph (2)(C), the justification from the entity for any such nonparticipation.*

*(4) USE OF FUNDS.—Amounts received under a grant under paragraph (1) shall be used to establish and implement a regional or local health information plan in accordance with this subsection.*

*(5) MATCHING REQUIREMENT.—*

*(A) IN GENERAL.—The Secretary may not make a grant under this subsection to an entity unless the entity agrees that, with respect to the costs to be incurred by the entity in carrying out the infrastructure program for which the grant was awarded, the entity will make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount equal to not less than 50 percent of such costs ($1 for each $2 of Federal funds provided under the grant).*

*(B) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions required under subparagraph (A) may be in cash or in kind, fairly evaluated, including equipment, technology, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.*

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

*(1) a description of the financial costs and benefits of the project involved and of the entities to which such costs and benefits accrue;*

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

*(3) a description of any reduction in duplicative or unnecessary care as a result of the project involved;*

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

*(5) other information as required by the Secretary.*

*(e) REQUIREMENT TO ACHIEVE QUALITY IMPROVEMENT.—The Secretary shall annually evaluate the activities conducted under this section and shall, in awarding grants, implement the lessons learned from such evaluation in a manner so that awards made subsequent to each such evaluation are made in a manner that, in the determination of the Secretary, will result in the greatest improvement in quality measurement systems under section 2908.*

*(f) LIMITATION.—An eligible entity may only receive one non-renewable grant under subjection (a), one non-renewable grant under subsection (b), and one non-renewable grand under subsection (c).*

*(g) AUTHORIZATION OF APPROPRIATIONS.—*

*(1) IN GENERAL.—For the purpose of carrying out this section, there is authorized to be appropriated $116,000,000 for fiscal year 2006, $141,000,000 for fiscal year 2007, and such sums as may be necessary for each of fiscal years 2008 through 2010.*

*(2) AVAILABILITY.—Amounts appropriated under paragraph (1) shall remain available through fiscal year 2010.*

***SEC. 2906. DEMONSTRATION PROGRAM TO INTEGRATE INFORMATION TECHNOLOGY INTO CLINICAL EDUCATION.***

*(a) IN GENERAL.—The Secretary may award grants under this section to carry out demonstration projects to develop academic curricula integrating qualified health information technology systems in the clinical education of health professionals. Such awards shall be made on a competitive basis and pursuant to peer review.*

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

*(1) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;*

*(2) submit to the Secretary a strategic plan for integrating qualified health information technology in the clinical education of health professionals and for ensuring the consistent utilization of decision support software to reduce medical errors and enhance health care quality;*

*(3) be—*

*(A) a health professions school;*

*(B) a school of nursing; or*

*(C) an institution with a graduate medical education program;*

*(4) provide for the collection of data regarding the effectiveness of the demonstration project to be funded under the grant in improving the safety of patients, the efficiency of health care delivery, and in increasing the likelihood that graduates of the grantee will adopt and incorporate health information technology, and implement the quality measurement system adopted under section 2908, in the delivery of health care services; and*

*(5) provide matching funds in accordance with subsection (c).*

*(c) USE OF FUNDS.—*

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

*(A) use grant funds in collaboration with 2 or more disciplines; and*

*(B) use grant funds to integrate qualified health information technology into community-based clinical education.*

*(2) LIMITATION.—An eligible entity shall not use amounts received under a grant under subsection (a) to purchase hardware, software, or services.*

*(d) MATCHING FUNDS.—*

*(1) IN GENERAL.—The Secretary may award a grant to an entity under this section only if the entity agrees to make available non-Federal contributions toward the costs of the program to be funded under the grant in an amount that is not less than $1 for each $2 of Federal funds provided under the grant.*

*(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions under paragraph (1) may be in cash or in kind, fairly evaluated, including equipment or services. Amounts pro-*

*vided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such contributions.*

*(e) EVALUATION.—The Secretary shall take such action as may be necessary to evaluate the projects funded under this section and publish, make available, and disseminate the results of such evaluations on as wide a basis as is practicable.*

*(f) REPORTS.—Not later than 1 year after the date of enactment of this title, and annually thereafter, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate, and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives a report that—*

*(1) describes the specific projects established under this section; and*

*(2) contains recommendations for Congress based on the evaluation conducted under subsection (e).*

*(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $5,000,000 for fiscal year 2007, and such sums as may be necessary for each of fiscal years 2008 through 2010.*

*(h) SUNSET.—This section shall not apply after September 30, 2010.*

***SEC. 2907. LICENSURE AND THE ELECTRONIC EXCHANGE OF HEALTH INFORMATION.***

*(a) IN GENERAL.—The Secretary shall carry out, or contract with a private entity to carry out, a study that examines—*

*(1) the variation among State laws that relate to the licensure, registration, and certification of medical professionals; and*

*(2) how such variation among State laws impacts the secure electronic exchange of health information—*

*(A) among the States; and*

*(B) between the States and the Federal Government.*

*(b) REPORT AND RECOMMENDATIONS.—Not later than 1 year after the date of enactment of this title, the Secretary shall publish a report that—*

*(1) describes the results of the study carried out under subsection (a); and*

*(2) makes recommendations to States regarding the harmonization of State laws based on the results of such study.*

***SEC. 2908. QUALITY MEASUREMENT SYSTEMS.***

*(a) IN GENERAL.—The Secretary, in consultation with the Secretary of Veterans Affairs, the Secretary of Defense, and representatives of other relevant Federal agencies, as determined appropriate by the Secretary, shall develop or adopt a quality measurement system, including measures to assess that effectiveness, timeliness, patient self-management, patient centeredness, efficiency, and safety, for the purpose of measuring the quality of care patients receive.*

*(b) REQUIREMENTS.—The Secretaries shall ensure that the quality measurement system developed under subsection (a) comply with the following:*

*(1) MEASURES.—*

*(A) IN GENERAL.—Subject to subparagraph (B), the Secretaries shall select measures of quality to be used by the Secretaries under the systems.*

*(B) REQUIREMENTS.—In selecting the measures to be used under each system pursuant to subparagraph (A), the Secretaries shall, to the extent feasible, ensure that—*

*(i) such measures are evidence based, reliable and valid;*

*(ii) such measures include measures of process, structure, patient experience, efficiency, and equity; and*

*(iii) such measures include measures of overuse, underuse, and misuse of health care items and services.*

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

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

*(B) measures that may be rapidly implemented by group health plans, health insurance issuers, physicians, hospitals, nursing homes, long-term care providers, and other providers; and*

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

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

*(4) RISK ADJUSTMENT.—The Secretaries shall establish procedures to account for differences in patient health status, patient characteristics, and geographic location. To the extent practicable, such procedures shall recognize existing procedures.*

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

*(A) the addition of more accurate and precise measures under the systems and the retirement of existing outdated measures under the systems; and*

*(B) the refinement of the weights assigned to measures under the systems.*

*(c) REQUIRED CONSIDERATIONS IN DEVELOPING AND UPDATING THE SYSTEMS.—In developing and updating the quality measurement systems under this section, the Secretaries shall—*

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

*(2) consult with representatives of health care providers, consumers, employers, and other individuals and groups that are interested in the quality of health care; and*

*(3) take into account—*

*(A) any demonstration or pilot program conducted by the Secretaries relating to measuring and rewarding quality and efficiency of care;*

*(B) any existing activities conducted by the Secretaries relating to measuring and rewarding quality and efficiency;*

*(C) any existing activities conducted by private entities including health insurance plans and payors; and*

*(D) the report by the Institute of Medicine of the National Academy of Sciences under section 238(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.*

*(d) REQUIRED CONSIDERATIONS IN IMPLEMENTING THE SYSTEMS.—In implementing the quality measurement systems under this section, the Secretaries shall take into account the recommendations of public-private entities—*

*(1) that are established to examine issues of data collection and reporting, including the feasibility of collecting and reporting data on measures; and*

*(2) that involve representatives of health care providers, consumers, employers, and other individuals and groups that are interested in quality of care.*

*(e) ARRANGEMENT WITH AN ENTITY TO PROVIDE ADVICE AND RECOMMENDATIONS.—*

*(1) ARRANGEMENT.—On and after July 1, 2006, the Secretaries shall have in place an arrangement with an entity that meets the requirements described in paragraph (2) under which such entity provides the Secretary with advice on, and recommendations with respect to, the development and updating of the quality measurement systems under this section, including the assigning of weights to the measures under subsection (b)(2).*

*(2) REQUIREMENTS DESCRIBED.—The requirements described in this paragraph are the following:*

*(A) The entity is a private nonprofit entity governed by an executive director and a board.*

*(B) The members of the entity include representatives of—*

*(i) health insurance plans and providers with experience in the care of individuals with multiple complex chronic conditions or groups representing such health insurance plans and providers;*

*(ii) groups representing patients and consumers;*

*(iii) purchasers and employers or groups representing purchasers or employers;*

*(iv) organizations that focus on quality improvement as well as the measurement and reporting of quality measures;*

*(v) State government health programs;*

*(vi) individuals or entities skilled in the conduct and interpretation of biomedical, health services, and health economics research and with expertise in outcomes and effectiveness research and technology assessment; and*

*(vii) individuals or entities involved in the development and establishment of standards and certification for health information technology systems and clinical data.*

*(C) The membership of the entity is representative of individuals with experience with urban health care issues and individuals with experience with rural and frontier health care issues.*

*(D) If the entity requires a fee for membership, the entity shall provide assurances to the Secretary that such fees are not a substantial barrier to participation in the entity's activities related to the arrangement with the Secretary.*

*(E) The entity—*

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

*(ii) ensures that member voting provides a balance among disparate stakeholders, so that no member organization described in subparagraph (B) unduly influences the outcome.*

*(F) With respect to matters related to the arrangement with the Secretary under paragraph (1), the entity conducts its business in an open and transparent manner and provides the opportunity for public comment.*

*(G) The entity operates as a voluntary consensus standards setting organization as defined for purposes of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (Public Law 104–113) and Office of Management and Budget Revised Circular A–119 (published in the Federal Register on February 10, 1998).*

*(f) USE OF QUALITY MEASUREMENT SYSTEM.—*

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

*(2) COLLABORATIVE AGREEMENTS.—With respect to activities conducted or supported by the Secretary under this Act, the Secretary may establish collaborative agreements with private entities, including group health plans and health insurance issuers, providers, purchasers, consumer organizations, and entities receiving a grant under section 2905, to—*

*(A) encourage the use of the health care quality measures adopted by the Secretary under this section; and*

*(B) foster uniformity between the health care quality measures utilized by private entities.*

*(3) REPORTING.—The Secretary shall implement procedures to enable the Department of Health and Human Services to accept the electronic submission of data for purposes of quality measurement using the quality measurement system adopted under this section and using the standards adopted by the Federal Government under section 2903.*

*(g) DISSEMINATION OF INFORMATION.—Beginning on January 1, 2008, in order to make comparative quality information available to health care consumers, health professionals, public health officials, researchers, and other appropriate individuals and entities, the Secretary shall provide for the aggregation and analysis of quality measures collected under section 2905 and the dissemination of recommendations and best practices derived in part from such analysis.*

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

*(1) implement and use evidence-based guidelines with the greatest potential to improve health care quality, efficiency, and patient safety; and*

*(2) establish mechanisms for the rapid dissemination of information regarding evidence-based guidelines with the greatest potential to improve health care quality, efficiency, and patient safety.*

***SEC. 2909. ENSURING PRIVACY AND SECURITY.***

*Nothing in this title shall be construed to affect the scope of substance of—*

*(1) section 264 of the Health Insurance Portability and Accountability Act of 1996;*

*(2) sections 1171 through 1179 of the Social Security Act; and*

*(3) any regulation issued pursuant to any such section;*

*and such sections shall remain in effect.*

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

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

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