

(2) provide training and technical assistance to State, community, and nonprofit respite care programs; and

(3) provide information, referral, and educational programs to the public on lifespan respite care.

(July 1, 1944, ch. 373, title XXIX, §2903, as added Pub. L. 109-442, §2, Dec. 21, 2006, 120 Stat. 3295.)

§ 300ii-3. Report

Not later than January 1, 2009, the Secretary shall report to the Congress on the activities undertaken under this subchapter. Such report shall evaluate—

(1) the number of States that have lifespan respite care programs;

(2) the demographics of the caregivers receiving respite care services through grants or cooperative agreements under this subchapter; and

(3) the effectiveness of entities receiving grants or cooperative agreements under this subchapter.

(July 1, 1944, ch. 373, title XXIX, §2904, as added Pub. L. 109-442, §2, Dec. 21, 2006, 120 Stat. 3295.)

§ 300ii-4. Authorization of appropriations

There are authorized to be appropriated to carry out this subchapter—

(1) \$30,000,000 for fiscal year 2007;

(2) \$40,000,000 for fiscal year 2008;

(3) \$53,330,000 for fiscal year 2009;

(4) \$71,110,000 for fiscal year 2010; and

(5) \$94,810,000 for fiscal year 2011.

(July 1, 1944, ch. 373, title XXIX, §2905, as added Pub. L. 109-442, §2, Dec. 21, 2006, 120 Stat. 3296.)

SUBCHAPTER XXVIII—HEALTH INFORMATION TECHNOLOGY AND QUALITY

§ 300jj. Definitions

In this subchapter:

(1) Certified EHR technology

The term “certified EHR technology” means a qualified electronic health record that is certified pursuant to section 300jj-11(c)(5) of this title as meeting standards adopted under section 300jj-14 of this title that are applicable to the type of record involved (as determined by the Secretary, such as an ambulatory electronic health record for office-based physicians or an inpatient hospital electronic health record for hospitals).

(2) Enterprise integration

The term “enterprise integration” means the electronic linkage of health care providers, health plans, the government, and other interested parties, to enable the electronic exchange and use of health information among all the components in the health care infrastructure in accordance with applicable law, and such term includes related application protocols and other related standards.

(3) Health care provider

The term “health care provider” includes a hospital, skilled nursing facility, nursing facility, home health entity or other long term

care facility, health care clinic, community mental health center (as defined in section 300x-2(b)(1) of this title), renal dialysis facility, blood center, ambulatory surgical center described in section 1395l(i) of this title,¹ emergency medical services provider, Federally qualified health center, group practice, a pharmacist, a pharmacy, a laboratory, a physician (as defined in section 1395x(r) of this title), a practitioner (as described in section 1395u(b)(18)(C) of this title), a provider operated by, or under contract with, the Indian Health Service or by an Indian tribe (as defined in the Indian Self-Determination and Education Assistance Act [25 U.S.C. 450 et seq.]), tribal organization, or urban Indian organization (as defined in section 1603 of title 25), a rural health clinic, a covered entity under section 256b of this title, an ambulatory surgical center described in section 1395l(i) of this title,¹ a therapist (as defined in section 1395w-4(k)(3)(B)(iii) of this title), and any other category of health care facility, entity, practitioner, or clinician determined appropriate by the Secretary.

(4) Health information

The term “health information” has the meaning given such term in section 1320d(4) of this title.

(5) Health information technology

The term “health information technology” means hardware, software, integrated technologies or related licenses, intellectual property, upgrades, or packaged solutions sold as services that are designed for or support the use by health care entities or patients for the electronic creation, maintenance, access, or exchange of health information²

(6) Health plan

The term “health plan” has the meaning given such term in section 1320d(5) of this title.

(7) HIT Policy Committee

The term “HIT Policy Committee” means such Committee established under section 300jj-12(a) of this title.

(8) HIT Standards Committee

The term “HIT Standards Committee” means such Committee established under section 300jj-13(a) of this title.

(9) Individually identifiable health information

The term “individually identifiable health information” has the meaning given such term in section 1320d(6) of this title.

(10) Laboratory

The term “laboratory” has the meaning given such term in section 263a(a) of this title.

(11) National Coordinator

The term “National Coordinator” means the head of the Office of the National Coordinator for Health Information Technology established under section 300jj-11(a) of this title.

¹So in original. The words “ambulatory surgical center described in section 1395l(i) of this title” appear in two places.

²So in original. Probably should be followed by a period.

(12) Pharmacist

The term “pharmacist” has the meaning given such term in section 384(2) of title 21.

(13) Qualified electronic health record

The term “qualified electronic health record” means an electronic record of health-related information on an individual that—

(A) includes patient demographic and clinical health information, such as medical history and problem lists; and

(B) has the capacity—

- (i) to provide clinical decision support;
- (ii) to support physician order entry;
- (iii) to capture and query information relevant to health care quality; and
- (iv) to exchange electronic health information with, and integrate such information from other sources.

(14) 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.

(July 1, 1944, ch. 373, title XXX, §3000, as added Pub. L. 111-5, div. A, title XIII, §13101, Feb. 17, 2009, 123 Stat. 228.)

REFERENCES IN TEXT

The Indian Self-Determination and Education Assistance Act, referred to in par. (3), is Pub. L. 93-638, Jan. 4, 1975, 88 Stat. 2203, which is classified principally to subchapter II (§450 et seq.) of chapter 14 of Title 25, Indians. For complete classification of this Act to the Code, see Short Title note set out under section 450 of Title 25 and Tables.

PART A—PROMOTION OF HEALTH INFORMATION TECHNOLOGY

§ 300jj-11. Office of the National Coordinator for Health Information Technology**(a) Establishment**

There is established within the Department of Health and Human Services an Office of the National Coordinator for 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 Secretary and shall report directly to the Secretary.

(b) Purpose

The National Coordinator shall perform the duties under subsection (c) in a manner consistent with the development of a nationwide health information technology infrastructure that allows for the electronic use and exchange of information and that—

- (1) ensures that each patient’s health information is secure and protected, in accordance with applicable law;
- (2) improves health care quality, reduces medical errors, reduces health disparities, and advances the delivery of patient-centered medical care;
- (3) reduces health care costs resulting from inefficiency, medical errors, inappropriate care, duplicative care, and incomplete information;
- (4) provides appropriate information to help guide medical decisions at the time and place of care;

(5) ensures the inclusion of meaningful public input in such development of such infrastructure;

(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 activities and facilitates the early identification and rapid response to public health threats and emergencies, including bioterror events and infectious disease outbreaks;

(8) facilitates health and clinical research and health care quality;

(9) promotes early detection, prevention, and management of chronic diseases;

(10) promotes a more effective marketplace, greater competition, greater systems analysis, increased consumer choice, and improved outcomes in health care services; and

(11) improves efforts to reduce health disparities.

(c) Duties of the National Coordinator**(1) Standards**

The National Coordinator shall—

(A) review and determine whether to endorse each standard, implementation specification, and certification criterion for the electronic exchange and use of health information that is recommended by the HIT Standards Committee under section 300jj-13 of this title for purposes of adoption under section 300jj-14 of this title;

(B) make such determinations under subparagraph (A), and report to the Secretary such determinations, not later than 45 days after the date the recommendation is received by the Coordinator; and

(C) review Federal health information technology investments to ensure that Federal health information technology programs are meeting the objectives of the strategic plan published under paragraph (3).

(2) HIT policy coordination**(A) In general**

The National Coordinator shall coordinate health information technology policy and programs of the Department with those of other relevant executive branch agencies 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 and in a manner towards a coordinated national goal.

(B) HIT policy and standards committees

The National Coordinator shall be a leading member in the establishment and operations of the HIT Policy Committee and the HIT Standards Committee and shall serve as a liaison among those two Committees and the Federal Government.

(3) Strategic plan**(A) In general**

The National Coordinator shall, in consultation with other appropriate Federal

agencies (including the National Institute of Standards and Technology), update the Federal Health IT Strategic Plan (developed as of June 3, 2008) to include specific objectives, milestones, and metrics with respect to the following:

(i) The electronic exchange and use of health information and the enterprise integration of such information.

(ii) The utilization of an electronic health record for each person in the United States by 2014.

(iii) The incorporation of privacy and security protections for the electronic exchange of an individual's individually identifiable health information.

(iv) Ensuring security methods to ensure appropriate authorization and electronic authentication of health information and specifying technologies or methodologies for rendering health information unusable, unreadable, or indecipherable.

(v) Specifying a framework for coordination and flow of recommendations and policies under this part among the Secretary, the National Coordinator, the HIT Policy Committee, the HIT Standards Committee, and other health information exchanges and other relevant entities.

(vi) Methods to foster the public understanding of health information technology.

(vii) Strategies to enhance the use of health information technology in improving the quality of health care, reducing medical errors, reducing health disparities, improving public health, increasing prevention and coordination with community resources, and improving the continuity of care among health care settings.

(viii) Specific plans for ensuring that populations with unique needs, such as children, are appropriately addressed in the technology design, as appropriate, which may include technology that automates enrollment and retention for eligible individuals.

(B) Collaboration

The strategic plan shall be updated through collaboration of public and private entities.

(C) Measurable outcome goals

The strategic plan update shall include measurable outcome goals.

(D) Publication

The National Coordinator shall republish the strategic plan, including all updates.

(4) Website

The National Coordinator shall maintain and frequently update an Internet website on which there is posted information on the work, schedules, reports, recommendations, and other information to ensure transparency in promotion of a nationwide health information technology infrastructure.

(5) Certification

(A) In general

The National Coordinator, in consultation with the Director of the National Institute

of Standards and Technology, shall keep or recognize a program or programs for the voluntary certification of health information technology as being in compliance with applicable certification criteria adopted under this part. Such program shall include, as appropriate, testing of the technology in accordance with section 17911(b) of this title.

(B) Certification criteria described

In this subchapter, the term "certification criteria" means, with respect to standards and implementation specifications for health information technology, criteria to establish that the technology meets such standards and implementation specifications.

(6) Reports and publications

(A) Report on additional funding or authority needed

Not later than 12 months after February 17, 2009, the National Coordinator shall submit to the appropriate committees of jurisdiction of the House of Representatives and the Senate a report on any additional funding or authority the Coordinator or the HIT Policy Committee or HIT Standards Committee requires to evaluate and develop standards, implementation specifications, and certification criteria, or to achieve full participation of stakeholders in the adoption of a nationwide health information technology infrastructure that allows for the electronic use and exchange of health information.

(B) Implementation report

The National Coordinator shall prepare a report that identifies lessons learned from major public and private health care systems in their implementation of health information technology, including information on whether the technologies and practices developed by such systems may be applicable to and usable in whole or in part by other health care providers.

(C) Assessment of impact of HIT on communities with health disparities and uninsured, underinsured, and medically underserved areas

The National Coordinator shall assess and publish the impact of health information technology in communities with health disparities and in areas with a high proportion of individuals who are uninsured, underinsured, and medically underserved individuals (including urban and rural areas) and identify practices to increase the adoption of such technology by health care providers in such communities, and the use of health information technology to reduce and better manage chronic diseases.

(D) Evaluation of benefits and costs of the electronic use and exchange of health information

The National Coordinator shall evaluate and publish evidence on the benefits and costs of the electronic use and exchange of health information and assess to whom these benefits and costs accrue.

(E) Resource requirements

The National Coordinator shall estimate and publish resources required annually to reach the goal of utilization of an electronic health record for each person in the United States by 2014, including—

- (i) the required level of Federal funding;
- (ii) expectations for regional, State, and private investment;
- (iii) the expected contributions by volunteers to activities for the utilization of such records; and
- (iv) the resources needed to establish a health information technology workforce sufficient to support this effort (including education programs in medical informatics and health information management).

(7) Assistance

The National Coordinator may provide financial assistance to consumer advocacy groups and not-for-profit entities that work in the public interest for purposes of defraying the cost to such groups and entities to participate under, whether in whole or in part, the National Technology Transfer Act of 1995 (15 U.S.C. 272 note).¹

(8) Governance for nationwide health information network

The National Coordinator shall establish a governance mechanism for the nationwide health information network.

(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) Chief Privacy Officer of the Office of the National Coordinator

Not later than 12 months after February 17, 2009, the Secretary shall appoint a Chief Privacy Officer of the Office of the National Coordinator, whose duty it shall be to advise the National Coordinator on privacy, security, and data stewardship of electronic health information and to coordinate with other Federal agencies (and similar privacy officers in such agencies), with

State and regional efforts, and with foreign countries with regard to the privacy, security, and data stewardship of electronic individually identifiable health information.

(July 1, 1944, ch. 373, title XXX, § 3001, as added Pub. L. 111-5, div. A, title XIII, § 13101, Feb. 17, 2009, 123 Stat. 230.)

REFERENCES IN TEXT

The National Technology Transfer Act of 1995 (15 U.S.C. 272 note), referred to in subsec. (c)(7), probably means section 12(d) of Pub. L. 104-113, known as the National Technology Transfer and Advancement Act of 1995, which is set out as a note under section 272 of Title 15, Commerce and Trade.

§ 300jj-12. HIT Policy Committee**(a) Establishment**

There is established a HIT Policy Committee to make policy recommendations to the National Coordinator relating to the implementation of a nationwide health information technology infrastructure, including implementation of the strategic plan described in section 300jj-11(c)(3) of this title.

(b) Duties**(1) Recommendations on health information technology infrastructure**

The HIT Policy Committee shall recommend a policy framework for the development and adoption of a nationwide health information technology infrastructure that permits the electronic exchange and use of health information as is consistent with the strategic plan under section 300jj-11(c)(3) of this title and that includes the recommendations under paragraph (2). The Committee shall update such recommendations and make new recommendations as appropriate.

(2) Specific areas of standard development**(A) In general**

The HIT Policy Committee shall recommend the areas in which standards, implementation specifications, and certification criteria are needed for the electronic exchange and use of health information for purposes of adoption under section 300jj-14 of this title and shall recommend an order of priority for the development, harmonization, and recognition of such standards, specifications, and certification criteria among the areas so recommended. Such standards and implementation specifications shall include named standards, architectures, and software schemes for the authentication and security of individually identifiable health information and other information as needed to ensure the reproducible development of common solutions across disparate entities.

(B) Areas required for consideration

For purposes of subparagraph (A), the HIT Policy Committee shall make recommendations for at least the following areas:

- (i) Technologies that protect the privacy of health information and promote security in a qualified electronic health record, including for the segmentation and protec-

¹ See References in Text note below.

tion from disclosure of specific and sensitive individually identifiable health information with the goal of minimizing the reluctance of patients to seek care (or disclose information about a condition) because of privacy concerns, in accordance with applicable law, and for the use and disclosure of limited data sets of such information.

(ii) A nationwide health information technology infrastructure that allows for the electronic use and accurate exchange of health information.

(iii) The utilization of a certified electronic health record for each person in the United States by 2014.

(iv) Technologies that as a part of a qualified electronic health record allow for an accounting of disclosures made by a covered entity (as defined for purposes of regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996) for purposes of treatment, payment, and health care operations (as such terms are defined for purposes of such regulations).

(v) The use of certified electronic health records to improve the quality of health care, such as by promoting the coordination of health care and improving continuity of health care among health care providers, by reducing medical errors, by improving population health, by reducing health disparities, by reducing chronic disease, and by advancing research and education.

(vi) Technologies that allow individually identifiable health information to be rendered unusable, unreadable, or indecipherable to unauthorized individuals when such information is transmitted in the nationwide health information network or physically transported outside of the secured, physical perimeter of a health care provider, health plan, or health care clearinghouse.

(vii) The use of electronic systems to ensure the comprehensive collection of patient demographic data, including, at a minimum, race, ethnicity, primary language, and gender information.

(viii) Technologies that address the needs of children and other vulnerable populations.

(C) Other areas for consideration

In making recommendations under subparagraph (A), the HIT Policy Committee may consider the following additional areas:

(i) The appropriate uses of a nationwide health information infrastructure, including for purposes of—

- (I) the collection of quality data and public reporting;
- (II) biosurveillance and public health;
- (III) medical and clinical research; and
- (IV) drug safety.

(ii) Self-service technologies that facilitate the use and exchange of patient information and reduce wait times.

(iii) Telemedicine technologies, in order to reduce travel requirements for patients in remote areas.

(iv) Technologies that facilitate home health care and the monitoring of patients recuperating at home.

(v) Technologies that help reduce medical errors.

(vi) Technologies that facilitate the continuity of care among health settings.

(vii) Technologies that meet the needs of diverse populations.

(viii) Methods to facilitate secure access by an individual to such individual's protected health information.

(ix) Methods, guidelines, and safeguards to facilitate secure access to patient information by a family member, caregiver, or guardian acting on behalf of a patient due to age-related and other disability, cognitive impairment, or dementia.

(x) Any other technology that the HIT Policy Committee finds to be among the technologies with the greatest potential to improve the quality and efficiency of health care.

(3) Forum

The HIT Policy Committee shall serve as a forum for broad stakeholder input with specific expertise in policies relating to the matters described in paragraphs (1) and (2).

(4) Consistency with evaluation conducted under MIPPA

(A) Requirement for consistency

The HIT Policy Committee shall ensure that recommendations made under paragraph (2)(B)(vi) are consistent with the evaluation conducted under section 1395b-10(a) of this title.

(B) Scope

Nothing in subparagraph (A) shall be construed to limit the recommendations under paragraph (2)(B)(vi) to the elements described in section 1395b-10(a)(3) of this title.

(C) Timing

The requirement under subparagraph (A) shall be applicable to the extent that evaluations have been conducted under section 1395b-10(a) of this title, regardless of whether the report described in subsection (b) of such section has been submitted.

(c) Membership and operations

(1) In general

The National Coordinator shall take a leading position in the establishment and operations of the HIT Policy Committee.

(2) Membership

The HIT Policy Committee shall be composed of members to be appointed as follows:

(A) 3 members shall be appointed by the Secretary, 1 of whom shall be appointed to represent the Department of Health and Human Services and 1 of whom shall be a public health official.

(B) 1 member shall be appointed by the majority leader of the Senate.

(C) 1 member shall be appointed by the minority leader of the Senate.

(D) 1 member shall be appointed by the Speaker of the House of Representatives.

(E) 1 member shall be appointed by the minority leader of the House of Representatives.

(F) Such other members as shall be appointed by the President as representatives of other relevant Federal agencies.

(G) 13 members shall be appointed by the Comptroller General of the United States of whom—

(i) 3 members shall advocates¹ for patients or consumers;

(ii) 2 members shall represent health care providers, one of which shall be a physician;

(iii) 1 member shall be from a labor organization representing health care workers;

(iv) 1 member shall have expertise in health information privacy and security;

(v) 1 member shall have expertise in improving the health of vulnerable populations;

(vi) 1 member shall be from the research community;

(vii) 1 member shall represent health plans or other third-party payers;

(viii) 1 member shall represent information technology vendors;

(ix) 1 member shall represent purchasers or employers; and

(x) 1 member shall have expertise in health care quality measurement and reporting.

(3) Participation

The members of the HIT Policy Committee appointed under paragraph (2) shall represent a balance among various sectors of the health care system so that no single sector unduly influences the recommendations of the Policy Committee.

(4) Terms

(A) In general

The terms of the members of the HIT Policy Committee shall be for 3 years, except that the Comptroller General shall designate staggered terms for the members first appointed.

(B) Vacancies

Any member appointed to fill a vacancy in the membership of the HIT Policy Committee that occurs prior to the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has been appointed. A vacancy in the HIT Policy Committee shall be filled in the manner in which the original appointment was made.

(5) Outside involvement

The HIT Policy Committee shall ensure an opportunity for the participation in activities of the Committee of outside advisors, including individuals with expertise in the development of policies for the electronic exchange and use of health information, including in the areas of health information privacy and security.

(6) Quorum

A majority of the member of the HIT Policy Committee shall constitute a quorum for purposes of voting, but a lesser number of members may meet and hold hearings.

(7) Failure of initial appointment

If, on the date that is 45 days after February 17, 2009, an official authorized under paragraph (2) to appoint one or more members of the HIT Policy Committee has not appointed the full number of members that such paragraph authorizes such official to appoint, the Secretary is authorized to appoint such members.

(8) Consideration

The National Coordinator shall ensure that the relevant and available recommendations and comments from the National Committee on Vital and Health Statistics are considered in the development of policies.

(d) Application of FACA

The Federal Advisory Committee Act (5 U.S.C. App.), other than section 14 of such Act, shall apply to the HIT Policy Committee.

(e) Publication

The Secretary shall provide for publication in the Federal Register and the posting on the Internet website of the Office of the National Coordinator for Health Information Technology of all policy recommendations made by the HIT Policy Committee under this section.

(July 1, 1944, ch. 373, title XXX, §3002, as added Pub. L. 111-5, div. A, title XIII, §13101, Feb. 17, 2009, 123 Stat. 234.)

REFERENCES IN TEXT

Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (b)(2)(B)(iv), is section 264(c) of Pub. L. 104-191, which is set out as a note under section 1320d-2 of this title.

The Federal Advisory Committee Act, referred to in subsec. (d), is Pub. L. 92-463, Oct. 6, 1972, 86 Stat. 770, which is set out in the Appendix to Title 5, Government Organization and Employees.

§ 300jj-13. HIT Standards Committee

(a) Establishment

There is established a committee to be known as the HIT Standards Committee to recommend to the National Coordinator standards, implementation specifications, and certification criteria for the electronic exchange and use of health information for purposes of adoption under section 300jj-14 of this title, consistent with the implementation of the strategic plan described in section 300jj-11(c)(3) of this title and beginning with the areas listed in section 300jj-12(b)(2)(B) of this title in accordance with policies developed by the HIT Policy Committee.

(b) Duties

(1) Standards development

(A) In general

The HIT Standards Committee shall recommend to the National Coordinator standards, implementation specifications, and certification criteria described in subsection

¹ So in original.

(a) that have been developed, harmonized, or recognized by the HIT Standards Committee. The HIT Standards Committee shall update such recommendations and make new recommendations as appropriate, including in response to a notification sent under section 300jj-14(a)(2)(B) of this title. Such recommendations shall be consistent with the latest recommendations made by the HIT Policy Committee.

(B) Harmonization

The HIT Standards Committee recognize¹ harmonized or updated standards from an entity or entities for the purpose of harmonizing or updating standards and implementation specifications in order to achieve uniform and consistent implementation of the standards and implementation specifications.

(C) Pilot testing of standards and implementation specifications

In the development, harmonization, or recognition of standards and implementation specifications, the HIT Standards Committee shall, as appropriate, provide for the testing of such standards and specifications by the National Institute for Standards and Technology under section 17911(a) of this title.

(D) Consistency

The standards, implementation specifications, and certification criteria recommended under this subsection shall be consistent with the standards for information transactions and data elements adopted pursuant to section 1320d-2 of this title.

(2) Forum

The HIT Standards Committee shall serve as a forum for the participation of a broad range of stakeholders to provide input on the development, harmonization, and recognition of standards, implementation specifications, and certification criteria necessary for the development and adoption of a nationwide health information technology infrastructure that allows for the electronic use and exchange of health information.

(3) Schedule

Not later than 90 days after February 17, 2009, the HIT Standards Committee shall develop a schedule for the assessment of policy recommendations developed by the HIT Policy Committee under section 300jj-12 of this title. The HIT Standards Committee shall update such schedule annually. The Secretary shall publish such schedule in the Federal Register.

(4) Public input

The HIT Standards Committee shall conduct open public meetings and develop a process to allow for public comment on the schedule described in paragraph (3) and recommendations described in this subsection. Under such process comments shall be submitted in a timely manner after the date of publication of a recommendation under this subsection.

(5) Consideration

The National Coordinator shall ensure that the relevant and available recommendations and comments from the National Committee on Vital and Health Statistics are considered in the development of standards.

(c) Membership and operations

(1) In general

The National Coordinator shall take a leading position in the establishment and operations of the HIT Standards Committee.

(2) Membership

The membership of the HIT Standards Committee shall at least reflect providers, ancillary healthcare workers, consumers, purchasers, health plans, technology vendors, researchers, relevant Federal agencies, and individuals with technical expertise on health care quality, privacy and security, and on the electronic exchange and use of health information.

(3) Participation

The members of the HIT Standards Committee appointed under this subsection shall represent a balance among various sectors of the health care system so that no single sector unduly influences the recommendations of such Committee.

(4) Outside involvement

The HIT Policy Committee shall ensure an opportunity for the participation in activities of the Committee of outside advisors, including individuals with expertise in the development of standards for the electronic exchange and use of health information, including in the areas of health information privacy and security.

(5) Balance among sectors

In developing the procedures for conducting the activities of the HIT Standards Committee, the HIT Standards Committee shall act to ensure a balance among various sectors of the health care system so that no single sector unduly influences the actions of the HIT Standards Committee.

(6) Assistance

For the purposes of carrying out this section, the Secretary may provide or ensure that financial assistance is provided by the HIT Standards Committee to defray in whole or in part any membership fees or dues charged by such Committee to those consumer advocacy groups and not for profit entities that work in the public interest as a part of their mission.

(d) Application of FACA

The Federal Advisory Committee Act (5 U.S.C. App.), other than section 14, shall apply to the HIT Standards Committee.

(e) Publication

The Secretary shall provide for publication in the Federal Register and the posting on the Internet website of the Office of the National Coordinator for Health Information Technology of all recommendations made by the HIT Standards Committee under this section.

(July 1, 1944, ch. 373, title XXX, §3003, as added Pub. L. 111-5, div. A, title XIII, §13101, Feb. 17, 2009, 123 Stat. 238.)

¹ So in original.

REFERENCES IN TEXT

The Federal Advisory Committee Act, referred to in subsec. (d), is Pub. L. 92-463, Oct. 6, 1972, 86 Stat. 770, which is set out in the Appendix to Title 5, Government Organization and Employees.

§ 300jj-14. Process for adoption of endorsed recommendations; adoption of initial set of standards, implementation specifications, and certification criteria

(a) Process for adoption of endorsed recommendations

(1) Review of endorsed standards, implementation specifications, and certification criteria

Not later than 90 days after the date of receipt of standards, implementation specifications, or certification criteria endorsed under section 300jj-11(c) of this title, the Secretary, in consultation with representatives of other relevant Federal agencies, shall jointly review such standards, implementation specifications, or certification criteria and shall determine whether or not to propose adoption of such standards, implementation specifications, or certification criteria.

(2) Determination to adopt standards, implementation specifications, and certification criteria

If the Secretary determines—

(A) to propose adoption of any grouping of such standards, implementation specifications, or certification criteria, the Secretary shall, by regulation under section 553 of title 5, determine whether or not to adopt such grouping of standards, implementation specifications, or certification criteria; or

(B) not to propose adoption of any grouping of standards, implementation specifications, or certification criteria, the Secretary shall notify the National Coordinator and the HIT Standards Committee in writing of such determination and the reasons for not proposing the adoption of such recommendation.

(3) Publication

The Secretary shall provide for publication in the Federal Register of all determinations made by the Secretary under paragraph (1).

(b) Adoption of standards, implementation specifications, and certification criteria

(1) In general

Not later than December 31, 2009, the Secretary shall, through the rulemaking process consistent with subsection (a)(2)(A), adopt an initial set of standards, implementation specifications, and certification criteria for the areas required for consideration under section 300jj-12(b)(2)(B) of this title. The rulemaking for the initial set of standards, implementation specifications, and certification criteria may be issued on an interim, final basis.

(2) Application of current standards, implementation specifications, and certification criteria

The standards, implementation specifications, and certification criteria adopted before

February 17, 2009, through the process existing through the Office of the National Coordinator for Health Information Technology may be applied towards meeting the requirement of paragraph (1).

(3) Subsequent standards activity

The Secretary shall adopt additional standards, implementation specifications, and certification criteria as necessary and consistent with the schedule published under section 300jj-13(b)(2)¹ of this title.

(July 1, 1944, ch. 373, title XXX, §3004, as added Pub. L. 111-5, div. A, title XIII, §13101, Feb. 17, 2009, 123 Stat. 240.)

§ 300jj-15. Application and use of adopted standards and implementation specifications by Federal agencies

For requirements relating to the application and use by Federal agencies of the standards and implementation specifications adopted under section 300jj-14 of this title, see section 17901 of this title.

(July 1, 1944, ch. 373, title XXX, §3005, as added Pub. L. 111-5, div. A, title XIII, §13101, Feb. 17, 2009, 123 Stat. 241.)

§ 300jj-16. Voluntary application and use of adopted standards and implementation specifications by private entities

(a) In general

Except as provided under section 13112 of the HITECH Act [42 U.S.C. 17902], nothing in such Act or in the amendments made by such Act shall be construed—

(1) to require a private entity to adopt or comply with a standard or implementation specification adopted under section 300jj-14 of this title; or

(2) to provide a Federal agency authority, other than the authority such agency may have under other provisions of law, to require a private entity to comply with such a standard or implementation specification.

(b) Rule of construction

Nothing in this part shall be construed to require that a private entity that enters into a contract with the Federal Government apply or use the standards and implementation specifications adopted under section 300jj-14 of this title with respect to activities not related to the contract.

(July 1, 1944, ch. 373, title XXX, §3006, as added Pub. L. 111-5, div. A, title XIII, §13101, Feb. 17, 2009, 123 Stat. 241.)

REFERENCES IN TEXT

The HITECH Act, referred to in subsec. (a), is title XIII of div. A and title IV of div. B of Pub. L. 111-5, Feb. 17, 2009, 123 Stat. 226, 467, also known as the Health Information Technology for Economic and Clinical Health Act. For complete classification of this Act to the Code, see Short Title of 2009 Amendment note set out under section 201 of this title and Tables.

¹So in original. Probably should be a reference to section 300jj-13(b)(3).

§ 300jj-17. Federal health information technology**(a) In general**

The National Coordinator shall support the development and routine updating of qualified electronic health record technology (as defined in section 300jj of this title) consistent with subsections (b) and (c) and make available such qualified electronic health record technology unless the Secretary determines through an assessment that the needs and demands of providers are being substantially and adequately met through the marketplace.

(b) Certification

In making such electronic health record technology publicly available, the National Coordinator shall ensure that the qualified electronic health record technology described in subsection (a) is certified under the program developed under section 300jj-11(c)(3) of this title to be in compliance with applicable standards adopted under section 300jj-13(a) of this title.

(c) Authorization to charge a nominal fee

The National Coordinator may impose a nominal fee for the adoption by a health care provider of the health information technology system developed or approved under subsection¹ (a) and (b). Such fee shall take into account the financial circumstances of smaller providers, low income providers, and providers located in rural or other medically underserved areas.

(d) Rule of construction

Nothing in this section shall be construed to require that a private or government entity adopt or use the technology provided under this section.

(July 1, 1944, ch. 373, title XXX, §3007, as added Pub. L. 111-5, div. A, title XIII, §13101, Feb. 17, 2009, 123 Stat. 241.)

§ 300jj-18. Transitions**(a) ONCHIT**

To the extent consistent with section 300jj-11 of this title, all functions, personnel, assets, liabilities, and administrative actions applicable to the National Coordinator for Health Information Technology appointed under Executive Order No. 13335 or the Office of such National Coordinator on the date before February 17, 2009, shall be transferred to the National Coordinator appointed under section 300jj-11(a) of this title and the Office of such National Coordinator as of February 17, 2009.

(b) National eHealth Collaborative

Nothing in sections¹ 300jj-12 or 300jj-13 of this title or this subsection shall be construed as prohibiting the AHIC Successor, Inc. doing business as the National eHealth Collaborative from modifying its charter, duties, membership, and any other structure or function required to be consistent with section² 300jj-12 and 300jj-13 of this title so as to allow the Secretary to recog-

¹ So in original. Probably should be "subsections".

¹ So in original. Probably should be "section".

² So in original. Probably should be "sections".

nize such AHIC Successor, Inc. as the HIT Policy Committee or the HIT Standards Committee.

(c) Consistency of recommendations

In carrying out section 300jj-13(b)(1)(A) of this title, until recommendations are made by the HIT Policy Committee, recommendations of the HIT Standards Committee shall be consistent with the most recent recommendations made by such AHIC Successor, Inc.

(July 1, 1944, ch. 373, title XXX, §3008, as added Pub. L. 111-5, div. A, title XIII, §13101, Feb. 17, 2009, 123 Stat. 241.)

REFERENCES IN TEXT

Executive Order No. 13335, referred to in subsec. (a), is set out as a note under section 300u of this title.

§ 300jj-19. Miscellaneous provisions**(a) Relation to HIPAA privacy and security law****(1) In general**

With respect to the relation of this subchapter to HIPAA privacy and security law:

(A) This subchapter may not be construed as having any effect on the authorities of the Secretary under HIPAA privacy and security law.

(B) The purposes of this subchapter include ensuring that the health information technology standards and implementation specifications adopted under section 300jj-14 of this title take into account the requirements of HIPAA privacy and security law.

(2) Definition

For purposes of this section, the term "HIPAA privacy and security law" means—

(A) the provisions of part C of title XI of the Social Security Act [42 U.S.C. 1320d et seq.], section 264 of the Health Insurance Portability and Accountability Act of 1996, and subtitle D of title IV¹ of the Health Information Technology for Economic and Clinical Health Act; and

(B) regulations under such provisions.

(b) Flexibility

In administering the provisions of this subchapter, the Secretary shall have flexibility in applying the definition of health care provider under section 300jj(3) of this title, including the authority to omit certain entities listed in such definition when applying such definition under this subchapter, where appropriate.

(July 1, 1944, ch. 373, title XXX, §3009, as added Pub. L. 111-5, div. A, title XIII, §13101, Feb. 17, 2009, 123 Stat. 242.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (a)(2)(A), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Part C of title XI of the Act is classified generally to part C (§1320d et seq.) of subchapter XI of chapter 7 of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

Section 264 of the Health Insurance Portability and Accountability Act of 1996, referred to subsec. (a)(2)(A), is section 264 of Pub. L. 104-191, which is set out as a note under section 1320d-2 of this title.

¹ See References in Text note below.

The Health Information Technology for Economic and Clinical Health Act, referred to in subsec. (a)(2)(A), is title XIII of div. A and title IV of div. B of Pub. L. 111-5, Feb. 17, 2009, 123 Stat. 226, 467, also known as the HITECH Act. Subtitle D of title IV of the Act probably means subtitle D of title XIII of div. A of the Act, which is classified generally to subchapter III (§17921 et seq.) of chapter 156 of this title. Title IV of div. B of the Act does not contain a subtitle D. For complete classification of this Act to the Code, see Short Title of 2009 Amendment note set out under section 201 of this title and Tables.

PART B—INCENTIVES FOR THE USE OF HEALTH INFORMATION TECHNOLOGY

§ 300jj-31. Immediate funding to strengthen the health information technology infrastructure

(a) In general

The Secretary shall, using amounts appropriated under section 300jj-38 of this title, invest in the infrastructure necessary to allow for and promote the electronic exchange and use of health information for each individual in the United States consistent with the goals outlined in the strategic plan developed by the National Coordinator (and as available) under section 300jj-11 of this title. The Secretary shall invest funds through the different agencies with expertise in such goals, such as the Office of the National Coordinator for Health Information Technology, the Health Resources and Services Administration, the Agency for Healthcare Research and Quality, the Centers of Medicare & Medicaid Services, the Centers for Disease Control and Prevention, and the Indian Health Service to support the following:

(1) Health information technology architecture that will support the nationwide electronic exchange and use of health information in a secure, private, and accurate manner, including connecting health information exchanges, and which may include updating and implementing the infrastructure necessary within different agencies of the Department of Health and Human Services to support the electronic use and exchange of health information.

(2) Development and adoption of appropriate certified electronic health records for categories of health care providers not eligible for support under title XVIII or XIX of the Social Security Act [42 U.S.C. 1395 et seq., 1396 et seq.] for the adoption of such records.

(3) Training on and dissemination of information on best practices to integrate health information technology, including electronic health records, into a provider's delivery of care, consistent with best practices learned from the Health Information Technology Research Center developed under section 300jj-32(b) of this title, including community health centers receiving assistance under section 254b of this title, covered entities under section 256b of this title, and providers participating in one or more of the programs under titles XVIII, XIX, and XXI of the Social Security Act [42 U.S.C. 1395 et seq., 1396 et seq., 1397aa et seq.] (relating to Medicare, Medicaid, and the State Children's Health Insurance Program).

(4) Infrastructure and tools for the promotion of telemedicine, including coordina-

tion among Federal agencies in the promotion of telemedicine.

(5) Promotion of the interoperability of clinical data repositories or registries.

(6) Promotion of technologies and best practices that enhance the protection of health information by all holders of individually identifiable health information.

(7) Improvement and expansion of the use of health information technology by public health departments.

(b) Coordination

The Secretary shall ensure funds under this section are used in a coordinated manner with other health information promotion activities.

(c) Additional use of funds

In addition to using funds as provided in subsection (a), the Secretary may use amounts appropriated under section 300jj-38 of this title to carry out health information technology activities that are provided for under laws in effect on February 17, 2009.

(d) Standards for acquisition of health information technology

To the greatest extent practicable, the Secretary shall ensure that where funds are expended under this section for the acquisition of health information technology, such funds shall be used to acquire health information technology that meets applicable standards adopted under section 300jj-14 of this title. Where it is not practicable to expend funds on health information technology that meets such applicable standards, the Secretary shall ensure that such health information technology meets applicable standards otherwise adopted by the Secretary.

(July 1, 1944, ch. 373, title XXX, §3011, as added Pub. L. 111-5, div. A, title XIII, §13301, Feb. 17, 2009, 123 Stat. 246.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (a)(2), (3), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Titles XVIII, XIX, and XXI of the Act are classified generally to subchapters XVIII (§1395 et seq.), XIX (§1396 et seq.), and XXI (§1397aa et seq.) of chapter 7 of this title, respectively. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

§ 300jj-32. Health information technology implementation assistance

(a) Health information technology extension program

To assist health care providers to adopt, implement, and effectively use certified EHR technology that allows for the electronic exchange and use of health information, the Secretary, acting through the Office of the National Coordinator, shall establish a health information technology extension program to provide health information technology assistance services to be carried out through the Department of Health and Human Services. The National Coordinator shall consult with other Federal agencies with demonstrated experience and expertise in information technology services, such as the National Institute of Standards and Technology, in developing and implementing this program.

(b) Health Information Technology Research Center**(1) In general**

The Secretary shall create a Health Information Technology Research Center (in this section referred to as the “Center”) to provide technical assistance and develop or recognize best practices to support and accelerate efforts to adopt, implement, and effectively utilize health information technology that allows for the electronic exchange and use of information in compliance with standards, implementation specifications, and certification criteria adopted under section 300jj-14 of this title.

(2) Input

The Center shall incorporate input from—

(A) other Federal agencies with demonstrated experience and expertise in information technology services such as the National Institute of Standards and Technology;

(B) users of health information technology, such as providers and their support and clerical staff and others involved in the care and care coordination of patients, from the health care and health information technology industry; and

(C) others as appropriate.

(3) Purposes

The purposes of the Center are to—

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

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

(C) assemble, analyze, and widely disseminate evidence and experience related to the adoption, implementation, and effective use of health information technology that allows for the electronic exchange and use of information including through the regional centers described in subsection (c);

(D) provide technical assistance for the establishment and evaluation of regional and local health information networks to facilitate the electronic exchange of information across health care settings and improve the quality of health care;

(E) provide technical assistance for the development and dissemination of solutions to barriers to the exchange of electronic health information; and

(F) learn about effective strategies to adopt and utilize health information technology in medically underserved communities.

(c) Health information technology regional extension centers**(1) In general**

The Secretary shall provide assistance for the creation and support of regional centers (in this subsection referred to as “regional centers”) to provide technical assistance and disseminate best practices and other information learned from the Center to support and accelerate efforts to adopt, implement, and ef-

fectively utilize health information technology that allows for the electronic exchange and use of information in compliance with standards, implementation specifications, and certification criteria adopted under section 300jj-14 of this title. Activities conducted under this subsection shall be consistent with the strategic plan developed by the National Coordinator, (and, as available) under section 300jj-11 of this title.

(2) Affiliation

Regional centers shall be affiliated with any United States-based nonprofit institution or organization, or group thereof, that applies and is awarded financial assistance under this section. Individual awards shall be decided on the basis of merit.

(3) Objective

The objective of the regional centers is to enhance and promote the adoption of health information technology through—

(A) assistance with the implementation, effective use, upgrading, and ongoing maintenance of health information technology, including electronic health records, to healthcare providers nationwide;

(B) broad participation of individuals from industry, universities, and State governments;

(C) active dissemination of best practices and research on the implementation, effective use, upgrading, and ongoing maintenance of health information technology, including electronic health records, to health care providers in order to improve the quality of healthcare and protect the privacy and security of health information;

(D) participation, to the extent practicable, in health information exchanges;

(E) utilization, when appropriate, of the expertise and capability that exists in Federal agencies other than the Department; and

(F) integration of health information technology, including electronic health records, into the initial and ongoing training of health professionals and others in the healthcare industry that would be instrumental to improving the quality of healthcare through the smooth and accurate electronic use and exchange of health information.

(4) Regional assistance

Each regional center shall aim to provide assistance and education to all providers in a region, but shall prioritize any direct assistance first to the following:

(A) Public or not-for-profit hospitals or critical access hospitals.

(B) Federally qualified health centers (as defined in section 1395x(aa)(4) of this title).

(C) Entities that are located in rural and other areas that serve uninsured, underinsured, and medically underserved individuals (regardless of whether such area is urban or rural).

(D) Individual or small group practices (or a consortium thereof) that are primarily focused on primary care.

(5) Financial support

The Secretary may provide financial support to any regional center created under this subsection for a period not to exceed four years. The Secretary may not provide more than 50 percent of the capital and annual operating and maintenance funds required to create and maintain such a center, except in an instance of national economic conditions which would render this cost-share requirement detrimental to the program and upon notification to Congress as to the justification to waive the cost-share requirement.

(6) Notice of program description and availability of funds

The Secretary shall publish in the Federal Register, not later than 90 days after February 17, 2009, a draft description of the program for establishing regional centers under this subsection. Such description shall include the following:

- (A) A detailed explanation of the program and the programs¹ goals.
- (B) Procedures to be followed by the applicants.
- (C) Criteria for determining qualified applicants.
- (D) Maximum support levels expected to be available to centers under the program.

(7) Application review

The Secretary shall subject each application under this subsection to merit review. In making a decision whether to approve such application and provide financial support, the Secretary shall consider at a minimum the merits of the application, including those portions of the application regarding—

- (A) the ability of the applicant to provide assistance under this subsection and utilization of health information technology appropriate to the needs of particular categories of health care providers;
- (B) the types of service to be provided to health care providers;
- (C) geographical diversity and extent of service area; and
- (D) the percentage of funding and amount of in-kind commitment from other sources.

(8) Biennial evaluation

Each regional center which receives financial assistance under this subsection shall be evaluated biennially by an evaluation panel appointed by the Secretary. Each evaluation panel shall be composed of private experts, none of whom shall be connected with the center involved, and of Federal officials. Each evaluation panel shall measure the involved center's performance against the objective specified in paragraph (3). The Secretary shall not continue to provide funding to a regional center unless its evaluation is overall positive.

(9) Continuing support

After the second year of assistance under this subsection, a regional center may receive additional support under this subsection if it has received positive evaluations and a finding

by the Secretary that continuation of Federal funding to the center was in the best interest of provision of health information technology extension services.

(July 1, 1944, ch. 373, title XXX, §3012, as added Pub. L. 111-5, div. A, title XIII, §13301, Feb. 17, 2009, 123 Stat. 247.)

§ 300jj-33. State grants to promote health information technology**(a) In general**

The Secretary, acting through the National Coordinator, shall establish a program in accordance with this section to facilitate and expand the electronic movement and use of health information among organizations according to nationally recognized standards.

(b) Planning grants

The Secretary may award a grant to a State or qualified State-designated entity (as described in subsection (f)) that submits an application to the Secretary at such time, in such manner, and containing such information as the Secretary may specify, for the purpose of planning activities described in subsection (d).

(c) Implementation grants

The Secretary may award a grant to a State or qualified State designated¹ entity that—

- (1) has submitted, and the Secretary has approved, a plan described in subsection (e) (regardless of whether such plan was prepared using amounts awarded under subsection (b));² and
- (2) submits an application at such time, in such manner, and containing such information as the Secretary may specify.

(d) Use of funds

Amounts received under a grant under subsection (c) shall be used to conduct activities to facilitate and expand the electronic movement and use of health information among organizations according to nationally recognized standards through activities that include—

- (1) enhancing broad and varied participation in the authorized and secure nationwide electronic use and exchange of health information;
- (2) identifying State or local resources available towards a nationwide effort to promote health information technology;
- (3) complementing other Federal grants, programs, and efforts towards the promotion of health information technology;
- (4) providing technical assistance for the development and dissemination of solutions to barriers to the exchange of electronic health information;
- (5) promoting effective strategies to adopt and utilize health information technology in medically underserved communities;
- (6) assisting patients in utilizing health information technology;
- (7) encouraging clinicians to work with Health Information Technology Regional Extension Centers as described in section 300jj-32

¹ So in original. Probably should be "State-designated".

² So in original. Another closing parenthesis probably should precede the semicolon.

¹ So in original.

of this title, to the extent they are available and valuable;

(8) supporting public health agencies' authorized use of and access to electronic health information;

(9) promoting the use of electronic health records for quality improvement including through quality measures reporting; and

(10) such other activities as the Secretary may specify.

(e) Plan

(1) In general

A plan described in this subsection is a plan that describes the activities to be carried out by a State or by the qualified State-designated entity within such State to facilitate and expand the electronic movement and use of health information among organizations according to nationally recognized standards and implementation specifications.

(2) Required elements

A plan described in paragraph (1) shall—

(A) be pursued in the public interest;

(B) be consistent with the strategic plan developed by the National Coordinator, (and, as available) under section 300jj-11 of this title;

(C) include a description of the ways the State or qualified State-designated entity will carry out the activities described in subsection (b); and

(D) contain such elements as the Secretary may require.

(f) Qualified State-designated entity

For purposes of this section, to be a qualified State-designated entity, with respect to a State, an entity shall—

(1) be designated by the State as eligible to receive awards under this section;

(2) be a not-for-profit entity with broad stakeholder representation on its governing board;

(3) demonstrate that one of its principal goals is to use information technology to improve health care quality and efficiency through the authorized and secure electronic exchange and use of health information;

(4) adopt nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory participation by stakeholders; and

(5) conform to such other requirements as the Secretary may establish.

(g) Required consultation

In carrying out activities described in subsections (b) and (c), a State or qualified State-designated entity shall consult with and consider the recommendations of—

(1) health care providers (including providers that provide services to low income and underserved populations);

(2) health plans;

(3) patient or consumer organizations that represent the population to be served;

(4) health information technology vendors;

(5) health care purchasers and employers;

(6) public health agencies;

(7) health professions schools, universities and colleges;

(8) clinical researchers;

(9) other users of health information technology such as the support and clerical staff of providers and others involved in the care and care coordination of patients; and

(10) such other entities, as may be determined appropriate by the Secretary.

(h) Continuous improvement

The Secretary shall annually evaluate the activities conducted under this section and shall, in awarding grants under this section, 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 lead towards the greatest improvement in quality of care, decrease in costs, and the most effective authorized and secure electronic exchange of health information.

(i) Required match

(1) In general

For a fiscal year (beginning with fiscal year 2011), the Secretary may not make a grant under this section to a State unless the State agrees to make available non-Federal contributions (which may include in-kind contributions) toward the costs of a grant awarded under subsection (c) in an amount equal to—

(A) for fiscal year 2011, not less than \$1 for each \$10 of Federal funds provided under the grant;

(B) for fiscal year 2012, not less than \$1 for each \$7 of Federal funds provided under the grant; and

(C) for fiscal year 2013 and each subsequent fiscal year, not less than \$1 for each \$3 of Federal funds provided under the grant.

(2) Authority to require State match for fiscal years before fiscal year 2011

For any fiscal year during the grant program under this section before fiscal year 2011, the Secretary may determine the extent to which there shall be required a non-Federal contribution from a State receiving a grant under this section.

(July 1, 1944, ch. 373, title XXX, §3013, as added Pub. L. 111-5, div. A, title XIII, §13301, Feb. 17, 2009, 123 Stat. 250.)

§ 300jj-34. Competitive grants to States and Indian tribes for the development of loan programs to facilitate the widespread adoption of certified EHR technology

(a) In general

The National Coordinator may award competitive grants to eligible entities for the establishment of programs for loans to health care providers to conduct the activities described in subsection (e).

(b) Eligible entity defined

For purposes of this subsection, the term “eligible entity” means a State or Indian tribe (as defined in the Indian Self-Determination and Education Assistance Act [25 U.S.C. 450 et seq.]) that—

(1) submits to the National Coordinator an application at such time, in such manner, and

containing such information as the National Coordinator may require;

(2) submits to the National Coordinator a strategic plan in accordance with subsection (d) and provides to the National Coordinator assurances that the entity will update such plan annually in accordance with such subsection;

(3) provides assurances to the National Coordinator that the entity will establish a Loan Fund in accordance with subsection (c);

(4) provides assurances to the National Coordinator that the entity will not provide a loan from the Loan Fund to a health care provider unless the provider agrees to—

(A) submit reports on quality measures adopted by the Federal Government (by not later than 90 days after the date on which such measures are adopted), to—

(i) the Administrator of the Centers for Medicare & Medicaid Services (or his or her designee), in the case of an entity participating in the Medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] or the Medicaid program under title XIX of such Act [42 U.S.C. 1396 et seq.]; or

(ii) the Secretary in the case of other entities;

(B) demonstrate to the satisfaction of the Secretary (through criteria established by the Secretary) that any certified EHR technology purchased, improved, or otherwise financially supported under a loan under this section is used to exchange health information in a manner that, in accordance with law and standards (as adopted under section 300jj-14 of this title) applicable to the exchange of information, improves the quality of health care, such as promoting care coordination; and¹

(C) comply with such other requirements as the entity or the Secretary may require;

(D) include a plan on how health care providers involved intend to maintain and support the certified EHR technology over time;

(E) include a plan on how the health care providers involved intend to maintain and support the certified EHR technology that would be purchased with such loan, including the type of resources expected to be involved and any such other information as the State or Indian Tribe, respectively, may require; and

(5) agrees to provide matching funds in accordance with subsection (h).

(c) Establishment of fund

For purposes of subsection (b)(3), an eligible entity shall establish a certified EHR technology loan fund (referred to in this subsection as a “Loan Fund”) and comply with the other requirements contained in this section. A grant to an eligible entity under this section shall be deposited in the Loan Fund established by the eligible entity. No funds authorized by other provisions of this subchapter to be used for other purposes specified in this subchapter shall be deposited in any Loan Fund.

¹ So in original. The word “and” probably should appear at end of subpar. (D).

(d) Strategic plan

(1) In general

For purposes of subsection (b)(2), a strategic plan of an eligible entity under this subsection shall identify the intended uses of amounts available to the Loan Fund of such entity.

(2) Contents

A strategic plan under paragraph (1), with respect to a Loan Fund of an eligible entity, shall include for a year the following:

(A) A list of the projects to be assisted through the Loan Fund during such year.

(B) A description of the criteria and methods established for the distribution of funds from the Loan Fund during the year.

(C) A description of the financial status of the Loan Fund as of the date of submission of the plan.

(D) The short-term and long-term goals of the Loan Fund.

(e) Use of funds

Amounts deposited in a Loan Fund, including loan repayments and interest earned on such amounts, shall be used only for awarding loans or loan guarantees, making reimbursements described in subsection (g)(4)(A), or as a source of reserve and security for leveraged loans, the proceeds of which are deposited in the Loan Fund established under subsection (c). Loans under this section may be used by a health care provider to—

(1) facilitate the purchase of certified EHR technology;

(2) enhance the utilization of certified EHR technology (which may include costs associated with upgrading health information technology so that it meets criteria necessary to be a certified EHR technology);

(3) train personnel in the use of such technology; or

(4) improve the secure electronic exchange of health information.

(f) Types of assistance

Except as otherwise limited by applicable State law, amounts deposited into a Loan Fund under this section may only be used for the following:

(1) To award loans that comply with the following:

(A) The interest rate for each loan shall not exceed the market interest rate.

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

(C) The Loan Fund shall be credited with all payments of principal and interest on each loan awarded from the Loan Fund.

(2) 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.

(3) As a source of revenue or security for the payment of principal and interest on revenue

or general obligation bonds issued by the eligible entity if the proceeds of the sale of the bonds will be deposited into the Loan Fund.

(4) To earn interest on the amounts deposited into the Loan Fund.

(5) To make reimbursements described in subsection (g)(4)(A).

(g) Administration of loan funds

(1) Combined financial administration

An eligible entity may (as a convenience and to avoid unnecessary administrative costs) combine, in accordance with applicable State law, the financial administration of a Loan Fund established under this subsection with the financial administration of any other revolving fund established by the entity if otherwise not prohibited by the law under which the Loan Fund was established.

(2) Cost of administering fund

Each eligible entity may annually use not to exceed 4 percent of the funds provided to the entity under a grant under this section to pay the reasonable costs of the administration of the programs under this section, including the recovery of reasonable costs expended to establish a Loan Fund which are incurred after February 17, 2009.

(3) Guidance and regulations

The National Coordinator shall publish guidance and promulgate regulations as may be necessary to carry out the provisions of this section, including—

(A) provisions to ensure that each eligible entity commits and expends funds allotted to the entity under this section as efficiently as possible in accordance with this subchapter and applicable State laws; and

(B) guidance to prevent waste, fraud, and abuse.

(4) Private sector contributions

(A) In general

A Loan Fund established under this section 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. An eligible entity may agree to reimburse a private sector entity for any contribution made under this subparagraph, except that the amount of such reimbursement may not be greater than the principal amount of the contribution made.

(B) Availability of information

An eligible entity shall make publicly available the identity of, and amount contributed by, any private sector entity under subparagraph (A) and may issue letters of commendation or make other awards (that have no financial value) to any such entity.

(h) Matching requirements

(1) In general

The National Coordinator may not make a grant under subsection (a) to an eligible entity unless the entity agrees to make available (directly or through donations from public or private entities) non-Federal contributions in

cash to the costs of carrying out the activities for which the grant is awarded in an amount equal to not less than \$1 for each \$5 of Federal funds provided under the grant.

(2) Determination of amount of non-Federal contribution

In determining the amount of non-Federal contributions that an eligible entity has provided pursuant to subparagraph (A),² the National Coordinator may not include any amounts provided to the entity by the Federal Government.

(i) Effective date

The Secretary may not make an award under this section prior to January 1, 2010.

(July 1, 1944, ch. 373, title XXX, §3014, as added Pub. L. 111-5, div. A, title XIII, §13301, Feb. 17, 2009, 123 Stat. 253.)

REFERENCES IN TEXT

The Indian Self-Determination and Education Assistance Act, referred to in subsec. (b), is Pub. L. 93-638, Jan. 4, 1975, 88 Stat. 2203, which is classified principally to subchapter II (§450 et seq.) of chapter 14 of Title 25, Indians. For complete classification of this Act to the Code, see Short Title note set out under section 450 of Title 25 and Tables.

The Social Security Act, referred to in subsec. (b)(4)(A)(i), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Titles XVIII and XIX of the Act are classified generally to subchapters XVIII (§1395 et seq.) and XIX (§1396 et seq.), respectively, of chapter 7 of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

§ 300jj-35. 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 certified EHR technology 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 certified EHR technology in the clinical education of health professionals to reduce medical errors, increase access to prevention, reduce chronic diseases, and enhance health care quality;

(3) be—

(A) a school of medicine, osteopathic medicine, dentistry, or pharmacy, a graduate program in behavioral or mental health, or any other graduate health professions school;

(B) a graduate school of nursing or physician assistant studies;

(C) a consortium of two or more schools described in subparagraph (A) or (B); or

²So in original. Probably means "paragraph (1),".

(D) an institution with a graduate medical education program in medicine, osteopathic medicine, dentistry, pharmacy, nursing, or physician assistance studies;

(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 certified EHR technology, in the delivery of health care services; and

(5) provide matching funds in accordance with subsection (d).

(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 certified EHR 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) Financial support

The Secretary may not provide more than 50 percent of the costs of any activity for which assistance is provided under subsection (a), except in an instance of national economic conditions which would render the cost-share requirement under this subsection detrimental to the program and upon notification to Congress as to the justification to waive the cost-share requirement.

(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 February 17, 2009, 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 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).

(July 1, 1944, ch. 373, title XXX, §3015, as added Pub. L. 111-5, div. A, title XIII, §13301, Feb. 17, 2009, 123 Stat. 256.)

§ 300jj-36. Information technology professionals in health care

(a) In general

The Secretary, in consultation with the Director of the National Science Foundation, shall

provide assistance to institutions of higher education (or consortia thereof) to establish or expand medical health informatics education programs, including certification, undergraduate, and masters degree programs, for both health care and information technology students to ensure the rapid and effective utilization and development of health information technologies (in the United States health care infrastructure).

(b) Activities

Activities for which assistance may be provided under subsection (a) may include the following:

(1) Developing and revising curricula in medical health informatics and related disciplines.

(2) Recruiting and retaining students to the program involved.

(3) Acquiring equipment necessary for student instruction in these programs, including the installation of testbed networks for student use.

(4) Establishing or enhancing bridge programs in the health informatics fields between community colleges and universities.

(c) Priority

In providing assistance under subsection (a), the Secretary shall give preference to the following:

(1) Existing education and training programs.

(2) Programs designed to be completed in less than six months.

(July 1, 1944, ch. 373, title XXX, §3016, as added Pub. L. 111-5, div. A, title XIII, §13301, Feb. 17, 2009, 123 Stat. 257.)

§ 300jj-37. General grant and loan provisions

(a) Reports

The Secretary may require that an entity receiving assistance under this part shall submit to the Secretary, not later than the date that is 1 year after the date of receipt of such assistance, a report that includes—

(1) an analysis of the effectiveness of the activities for which the entity receives such assistance, as compared to the goals for such activities; and

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

(b) Requirement to improve quality of care and decrease in costs

The National Coordinator shall annually evaluate the activities conducted under this part 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 National Coordinator, will result in the greatest improvement in the quality and efficiency of health care.

(July 1, 1944, ch. 373, title XXX, §3017, as added Pub. L. 111-5, div. A, title XIII, §13301, Feb. 17, 2009, 123 Stat. 257.)

§ 300jj-38. Authorization for appropriations

For the purposes of carrying out this part, there is authorized to be appropriated such sums

as may be necessary for each of the fiscal years 2009 through 2013.

(July 1, 1944, ch. 373, title XXX, §3018, as added Pub. L. 111-5, div. A, title XIII, §13301, Feb. 17, 2009, 123 Stat. 258.)

PART C—OTHER PROVISIONS

§ 300jj-51. Health information technology enrollment standards and protocols

(a) In general

(1) Standards and protocols

Not later than 180 days after March 23, 2010,¹ the Secretary, in consultation with the HIT Policy Committee and the HIT Standards Committee, shall develop interoperable and secure standards and protocols that facilitate enrollment of individuals in Federal and State health and human services programs, as determined by the Secretary.

(2) Methods

The Secretary shall facilitate enrollment in such programs through methods determined appropriate by the Secretary, which shall include providing individuals and third parties authorized by such individuals and their designees notification of eligibility and verification of eligibility required under such programs.

(b) Content

The standards and protocols for electronic enrollment in the Federal and State programs described in subsection (a) shall allow for the following:

(1) Electronic matching against existing Federal and State data, including vital records, employment history, enrollment systems, tax records, and other data determined appropriate by the Secretary to serve as evidence of eligibility and in lieu of paper-based documentation.

(2) Simplification and submission of electronic documentation, digitization of documents, and systems verification of eligibility.

(3) Reuse of stored eligibility information (including documentation) to assist with retention of eligible individuals.

(4) Capability for individuals to apply, recertify and manage their eligibility information online, including at home, at points of service, and other community-based locations.

(5) Ability to expand the enrollment system to integrate new programs, rules, and functionalities, to operate at increased volume, and to apply streamlined verification and eligibility processes to other Federal and State programs, as appropriate.

(6) Notification of eligibility, recertification, and other needed communication regarding eligibility, which may include communication via email and cellular phones.

(7) Other functionalities necessary to provide eligibles with streamlined enrollment process.

(c) Approval and notification

With respect to any standard or protocol developed under subsection (a) that has been ap-

proved by the HIT Policy Committee and the HIT Standards Committee, the Secretary—

(1) shall notify States of such standards or protocols; and

(2) may require, as a condition of receiving Federal funds for the health information technology investments, that States or other entities incorporate such standards and protocols into such investments.

(d) Grants for implementation of appropriate enrollment HIT

(1) In general

The Secretary shall award grant² to eligible entities to develop new, and adapt existing, technology systems to implement the HIT enrollment standards and protocols developed under subsection (a) (referred to in this subsection as “appropriate HIT technology”).

(2) Eligible entities

To be eligible for a grant under this subsection, an entity shall—

(A) be a State, political subdivision of a State, or a local governmental entity; and

(B) submit to the Secretary an application at such time, in such manner, and containing—

(i) a plan to adopt and implement appropriate enrollment technology that includes—

(I) proposed reduction in maintenance costs of technology systems;

(II) elimination or updating of legacy systems; and

(III) demonstrated collaboration with other entities that may receive a grant under this section that are located in the same State, political subdivision, or locality;

(ii) an assurance that the entity will share such appropriate enrollment technology in accordance with paragraph (4); and

(iii) such other information as the Secretary may require.

(3) Sharing

(A) In general

The Secretary shall ensure that appropriate enrollment HIT adopted under grants under this subsection is made available to other qualified State, qualified political subdivisions of a State, or other appropriate qualified entities (as described in subparagraph (B)) at no cost.

(B) Qualified entities

The Secretary shall determine what entities are qualified to receive enrollment HIT under subparagraph (A), taking into consideration the recommendations of the HIT Policy Committee and the HIT Standards Committee.

(July 1, 1944, ch. 373, title XXX, §3021, as added Pub. L. 111-148, title I, §1561, Mar. 23, 2010, 124 Stat. 262.)

REFERENCES IN TEXT

March 23, 2010, referred to in subsec. (a)(1), was in the original “the date of enactment of this title”, which

¹ See References in Text note below.

² So in original. Probably should be “grants”.

was translated as meaning the date of enactment of Pub. L. 111-148, which enacted this part, to reflect the probable intent of Congress.

SUBCHAPTER XXIX—DATA COLLECTION,
ANALYSIS, AND QUALITY

§ 300kk. Data collection, analysis, and quality

(a) Data collection

(1) In general

The Secretary shall ensure that, by not later than 2 years after March 23, 2010, any federally conducted or supported health care or public health program, activity or survey (including Current Population Surveys and American Community Surveys conducted by the Bureau of Labor Statistics and the Bureau of the Census) collects and reports, to the extent practicable—

(A) data on race, ethnicity, sex, primary language, and disability status for applicants, recipients, or participants;

(B) data at the smallest geographic level such as State, local, or institutional levels if such data can be aggregated;

(C) sufficient data to generate statistically reliable estimates by racial, ethnic, sex, primary language, and disability status subgroups for applicants, recipients or participants using, if needed, statistical oversamples of these subpopulations; and

(D) any other demographic data as deemed appropriate by the Secretary regarding health disparities.

(2) Collection standards

In collecting data described in paragraph (1), the Secretary or designee shall—

(A) use Office of Management and Budget standards, at a minimum, for race and ethnicity measures;

(B) develop standards for the measurement of sex, primary language, and disability status;

(C) develop standards for the collection of data described in paragraph (1) that, at a minimum—

(i) collects self-reported data by the applicant, recipient, or participant; and

(ii) collects data from a parent or legal guardian if the applicant, recipient, or participant is a minor or legally incapacitated;

(D) survey health care providers and establish other procedures in order to assess access to care and treatment for individuals with disabilities and to identify—

(i) locations where individuals with disabilities access primary, acute (including intensive), and long-term care;

(ii) the number of providers with accessible facilities and equipment to meet the needs of the individuals with disabilities, including medical diagnostic equipment that meets the minimum technical criteria set forth in section 794f of title 29; and

(iii) the number of employees of health care providers trained in disability awareness and patient care of individuals with disabilities; and

(E) require that any reporting requirement imposed for purposes of measuring quality under any ongoing or federally conducted or supported health care or public health program, activity, or survey includes requirements for the collection of data on individuals receiving health care items or services under such programs activities¹ by race, ethnicity, sex, primary language, and disability status.

(3) Data management

In collecting data described in paragraph (1), the Secretary, acting through the National Coordinator for Health Information Technology shall—

(A) develop national standards for the management of data collected; and

(B) develop interoperability and security systems for data management.

(b) Data analysis

(1)² In general

For each federally conducted or supported health care or public health program or activity, the Secretary shall analyze data collected under paragraph (a) to detect and monitor trends in health disparities (as defined for purposes of section 285t³ of this title) at the Federal and State levels.

(c) Data reporting and dissemination

(1) In general

The Secretary shall make the analyses described in (b)⁴ available to—

(A) the Office of Minority Health;

(B) the National Center on Minority Health and Health Disparities;

(C) the Agency for Healthcare Research and Quality;

(D) the Centers for Disease Control and Prevention;

(E) the Centers for Medicare & Medicaid Services;

(F) the Indian Health Service and epidemiology centers funded under the Indian Health Care Improvement Act [25 U.S.C. 1601 et seq.];

(G) the Office of Rural health;⁵

(H) other agencies within the Department of Health and Human Services; and

(I) other entities as determined appropriate by the Secretary.

(2) Reporting of data

The Secretary shall report data and analyses described in (a)⁶ and (b) through—

(A) public postings on the Internet websites of the Department of Health and Human Services; and

(B) any other reporting or dissemination mechanisms determined appropriate by the Secretary.

(3) Availability of data

The Secretary may make data described in (a) and (b) available for additional research,

¹ So in original.

² So in original. No par. (2) has been enacted.

³ See References in Text note below.

⁴ So in original. Probably should be preceded by "subsection".

⁵ So in original. Probably should be "Health;".

⁶ So in original. Probably should be preceded by "subsections".