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§ 300ii–2. National lifespan respite resource center
(a) Establishment
The Secretary may award a grant or cooperative agreement to a public or private nonprofit entity to establish a National Resource Center on Lifespan Respite Care (referred to in this section as the “center”).

(b) Purposes of the center
The center shall—
(1) maintain a national database on lifespan respite care;
(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.

§ 300ii–3. Data collection and reporting
(a) In general
Each State agency awarded a grant or cooperative agreement under section 300i–1 of this title shall report such data, information, and metrics as the Secretary may require for purposes of—
(1) evaluating State programs and activities funded pursuant to such grant or cooperative agreement, including any results pursuant to section 300ii–1(d)(2)(B)(xii) of this title; and
(2) identifying effective programs and activities funded pursuant to section 300i–1 of this title.

(b) Report
Not later than October 1, 2023, the Secretary shall submit a report to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives regarding the outcomes of the programs and activities funded pursuant to section 300i–1 of this title, including any effective programs and activities identified.


AMENDMENTS
2021—Pub. L. 116–324 amended section generally. Prior to amendment, section required the Secretary to report to Congress by Jan. 1, 2009, on the activities undertaken under this subchapter.

§ 300ii–4. Authorization of appropriations
There are authorized to be appropriated to carry out this subchapter, $10,000,000 for each of fiscal years 2020 through fiscal year 2024.


AMENDMENTS
2021—Pub. L. 116–324 substituted “subchapter, $10,000,000 for each of fiscal years 2020 through fiscal year 2024,” for “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.’’

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 1395(i)(1) of this title,1 emer-

1 So in original. The words “ambulatory surgical center described in section 1395(i)(1) of this title” appear in two places.
gency 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)(16)(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. 5301 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 1395t(i) of this title, 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 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 use by health care entities or patients for the services that are designed for or support the electronic creation, maintenance, access, or exchange of health information.

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

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

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

(9) Interoperability
The term “interoperability”, with respect to health information technology, means such health information technology that—

(A) enables the secure exchange of electronic health information with, and use of electronic health information from, other health information technology without special effort on the part of the user;

(B) allows for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable State or Federal law; and

(C) does not constitute information blocking as defined in section 300j–52(a) 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.

(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;

(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; and

(C) includes, or is capable of including, a real-time benefit tool that conveys patient-specific real-time cost and coverage information with respect to prescription drugs that, with respect to any health information technology certified for electronic prescribing, the technology shall be capable of incorporating the information described in clauses (i) through (iii) of paragraph (2)(B) of section 1395w–10(4)(c) of this title at a time specified by the Secretary but not before the Secretary adopts a standard for such tools as described in paragraph (1) of such section.

(15) * 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.

(17) Interoperability
The term “interoperability”, as used in this subpart—

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

(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; and

(C) includes, or is capable of including, a real-time benefit tool that conveys patient-specific real-time cost and coverage information with respect to prescription drugs that, with respect to any health information technology certified for electronic prescribing, the technology shall be capable of incorporating the information described in clauses (i) through (iii) of paragraph (2)(B) of section 1395w–10(4)(c) of this title at a time specified by the Secretary but not before the Secretary adopts a standard for such tools as described in paragraph (1) of such section.

* So in original. There is no par. (14).

REFERENCES IN TEXT

AMENDMENTS
2016—Par. (7). Pub. L. 114–255, §4003(e)(2)(B), added par. (7) and struck out former par. (5). Prior to amendment, text read as follows: “The term ‘HIT Policy Committee’ means such Committee established under section 300jj–12(a) of this title.”

So in original. Probably should be “(a)(2)”.

So in original. There is no par. (14).
amendment, text of par. (8) read as follows: “The term ‘HIT Standards Committee’ means such Committee established under section 300jj–11(a) of this title.”

§ 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 health 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) supports patient self-management and participation in health care decisions; and

(6) improves the efficiency and effectiveness of care through the coordination and integration of care delivered by appropriately qualified health care providers.

(c) Qualifications

The National Coordinator shall report to the Secretary at such frequencies as the Secretary may direct. The National Coordinator shall perform the duties under subsection (c) as the Secretary determines appropriate.

(d) Office of the National Coordinator

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’), in consultation with providers of health services, health care suppliers of services, health care payers, health professional societies, health care quality organizations, health care accreditation organizations, public health entities, States, and other appropriate entities, shall, in accordance with subsection (b)—

(1) establish a goal with respect to the reduction of regulatory or administrative burdens (such as documentation requirements) relating to the use of electronic health records;

(2) develop a strategy for meeting the goal established under paragraph (1); and

(3) develop recommendations for meeting the goal established under paragraph (1).

(b) STRATEGY AND RECOMMENDATIONS.—

(1) In general.—To achieve the goal established under subsection (a)(1), the Secretary, in consultation with the entities described in such subsection, shall not later than 1 year after the date of enactment of the 21st Century Cures Act [Dec. 13, 2016], develop a strategy and recommendations to meet the goal in accordance with this subsection.

(2) STRATEGY.—The strategy developed under paragraph (1) shall address the regulatory and administrative burdens (such as documentation requirements) relating to the use of electronic health records. Such strategy shall include broad public comment and shall prioritize—

(A) incentives for meaningful use of certified EHR technology for eligible professionals and hospitals under sections 1848(a)(7) and 1848(b)(3)(B)(ix), respectively, of the Social Security Act (42 U.S.C. 1395w–2a(7), 1395w–2a(3)(B)(ix));

(B) activities that provide individuals access to their electronic health information;

(C) standards and implementation specifications as appropriate;

(D) activities that provide individuals access to their electronic health information;

(E) activities related to protecting the privacy of electronic health information;

(F) activities related to protecting the security of electronic health information;

(G) activities related to facilitating health and clinical research;

(H) activities related to public health;

(I) activities related to aligning and simplifying quality measures across Federal programs and other payers;

(J) activities related to reporting clinical data for administrative purposes; and

(K) other areas, as the Secretary determines appropriate.

(c) APPLICATION OF CERTAIN REGULATORY REQUIREMENTS.—A physician (as defined in section 1861(r)(1) of the Social Security Act [42 U.S.C. 1395x(r)(1)]) to the extent consistent with applicable State law, may delegate electronic medical record documentation requirements specified in regulations promulgated by the Centers for Medicare & Medicaid Services to a person performing a scribe function who is not such physician if such physician has signed and verified the documentation.

(d) RECOMMENDATIONS.—The recommendations developed under paragraph (1) shall address—

(A) actions that improve the clinical documentation experience;

(B) actions that improve patient care;

(C) actions to be taken by the Secretary and by other entities; and

(D) other areas, as the Secretary determines appropriate, to reduce the reporting burden required of health care providers.

(E) FACIA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the development of the goal, strategies, or recommendations described in this section.

§ 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;