

109TH CONGRESS
2D SESSION

H. R. 4726

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

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 8, 2006

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

A BILL

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

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

3 **SECTION 1. SHORT TITLE.**

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

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

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

1 **“TITLE XXIX—HEALTH INFORMA-**
2 **TION TECHNOLOGY AND**
3 **QUALITY**

4 **“SEC. 2901. DEFINITIONS.**

5 “In this title:

6 “(1) HEALTH CARE PROVIDER.—The term
7 ‘health care provider’ means a hospital, skilled nurs-
8 ing facility, home health entity, health care clinic,
9 federally qualified health center, group practice (as
10 defined in section 1877(h)(4) of the Social Security
11 Act), a pharmacist, a pharmacy, a laboratory, a phy-
12 sician (as defined in section 1861(r) of the Social
13 Security Act), a practitioner (as defined in section
14 1842(b)(18)(CC) of the Social Security Act), a
15 health facility operated by or pursuant to a contract
16 with the Indian Health Service, a rural health clinic,
17 and any other category of facility or clinician deter-
18 mined appropriate by the Secretary.

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

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

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

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

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

5 “(4) INDIVIDUALLY IDENTIFIABLE HEALTH IN-
6 FORMATION.—The term ‘individually identifiable
7 health information’ has the meaning given such term
8 in section 1171 of the Social Security Act.

9 “(5) LABORATORY.—The term ‘laboratory’ has
10 the meaning given that term in section 353.

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

14 “(7) QUALIFIED HEALTH INFORMATION TECH-
15 NOLOGY.—The term ‘qualified health information
16 technology’ means a computerized system (including
17 hardware and software) that—

18 “(A) protects the privacy and security of
19 health information;

20 “(B) maintains and provides permitted ac-
21 cess to health information in an electronic for-
22 mat;

23 “(C) incorporates decision support to re-
24 duce medical errors and enhance health care
25 quality;

1 “(D) complies with the standards adopted
2 by the Federal Government under section 2903;
3 and

4 “(E) allows for the reporting of quality
5 measures under section 2907.

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

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

12 “(a) OFFICE OF NATIONAL HEALTH INFORMATION
13 TECHNOLOGY.—There is established within the Office of
14 the Secretary an Office of the National Coordinator of
15 Health Information Technology (referred to in this section
16 as the ‘Office’). The Office shall be headed by a National
17 Coordinator who shall be appointed by the Secretary and
18 shall report directly to the Secretary.

19 “(b) PURPOSE.—It shall be the purpose of the Office
20 to coordinate with relevant Federal agencies and private
21 entities and oversee programs and activities to develop a
22 nationwide interoperable health information technology in-
23 frastructure that—

24 “(1) ensures that patients’ individually identifi-
25 able health information is secure and protected;

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

4 “(3) reduces health care costs resulting from
5 inefficiency, medical errors, inappropriate care, and
6 incomplete information;

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

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

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

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

23 “(8) facilitates health research; and

24 “(9) promotes prevention of chronic diseases.

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

2 The National Coordinator shall—

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

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

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

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

23 “(5) to the extent permitted by law, coordinate
24 outreach and consultation by the relevant executive
25 branch agencies (including Federal commissions)

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

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

9 “(7) prepare the reports described under sec-
10 tion 2903(i) (excluding paragraph (4) of such sec-
11 tion).

12 “(d) DETAIL OF FEDERAL EMPLOYEES.—

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

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

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

“(B) be in addition to any other staff of
the Department employed by the National Co-
ordinator.

“(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.

9 “(e) RULE OF CONSTRUCTION.—Nothing in this sec-
10 tion shall be construed to require the duplication of Fed-
11 eral efforts with respect to the establishment of the Office,
12 regardless of whether such efforts were carried out prior
13 to or after the enactment of this title.

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

19 "SEC. 2903. AMERICAN HEALTH INFORMATION COLLABO-
20 RATIVE.

21 “(a) PURPOSE.—The Secretary shall establish the
22 public-private American Health Information Collaborative
23 (referred to in this section as the ‘Collaborative’) to—

1 “(1) advise the Secretary and recommend spe-
2 cific actions to achieve a nationwide interoperable
3 health information technology infrastructure;

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

8 “(3) recommend standards (including content,
9 communication, and security standards) for the elec-
10 tronic exchange of health information (including for
11 the reporting of quality data under section 2907) for
12 adoption by the Federal Government and voluntary
13 adoption by private entities.

14 “(b) COMPOSITION.—

15 “(1) IN GENERAL.—The Collaborative shall be
16 composed of members of the public and private sec-
17 tors to be appointed by the Secretary, including rep-
18 resentatives from—

19 “(A) consumer or patient organizations;

20 “(B) organizations with expertise in pri-
21 vacy and security;

22 “(C) health care providers;

23 “(D) health insurance plans or other third
24 party payors;

25 “(E) information technology vendors; and

1 “(F) purchasers or employers.

2 “(2) PARTICIPATION.—In appointing members
3 under paragraph (1), and in developing the proce-
4 dures for conducting the activities of the Collabo-
5 rative, the Secretary shall ensure a balance among
6 various sectors of the health care system so that no
7 single sector unduly influences the recommendations
8 of the Collaborative.

9 “(3) TERMS.—Members appointed under para-
10 graph (1) shall serve for 2 year terms, except that
11 any member appointed to fill a vacancy for an unex-
12 pired term shall be appointed for the remainder of
13 such term. A member may serve for not to exceed
14 180 days after the expiration of such member’s term
15 or until a successor has been appointed.

16 “(4) OUTSIDE INVOLVEMENT.—With respect to
17 the functions of the Collaborative, the Secretary
18 shall ensure an adequate opportunity for the partici-
19 pation of outside advisors, including individuals with
20 expertise in—

21 “(A) health information privacy;

22 “(B) health information security;

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

1 health information technology to improve health
2 care quality and patient safety;

3 “(D) data exchange; and

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

7 “(c) RECOMMENDATIONS AND POLICIES.—Not later
8 than 1 year after the date of enactment of this title, and
9 annually thereafter, the Collaborative shall recommend to
10 the Secretary uniform national policies for adoption by the
11 Federal Government and voluntary adoption by private en-
12 tities to support the widespread adoption of health infor-
13 mation technology, including—

14 “(1) protection of individually identifiable
15 health information through privacy and security
16 practices;

17 “(2) measures to prevent unauthorized access
18 to health information, including unauthorized access
19 through the use of certain peer-to-peer file-sharing
20 applications;

21 “(3) methods to notify patients if their individ-
22 ually identifiable health information is wrongfully
23 disclosed;

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

1 “(5) fostering the public understanding of
2 health information technology;

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

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

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

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

14 “(10) other policies (including recommendations
15 for incorporating health information technology into
16 the provision of care and the organization of the
17 health care workplace) determined to be necessary
18 by the Collaborative.

19 “(d) STANDARDS.—

20 “(1) EXISTING STANDARDS.—The standards
21 adopted by the Consolidated Health Informatics Ini-
22 tiative shall be deemed to have been recommended
23 by the Collaborative under this section.

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

4 “(A) review existing standards (including
5 content, communication, and security stand-
6 ards) for the electronic exchange of health in-
7 formation;

8 “(B) identify deficiencies and omissions in
9 such existing standards; and

10 “(C) identify duplication and overlap in
11 such existing standards;

12 and recommend new standards and modifications to
13 such existing standards as necessary.

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

17 “(A) review existing standards (including
18 content, communication, and security stand-
19 ards) for the electronic exchange of health in-
20 formation;

21 “(B) identify deficiencies and omissions in
22 such existing standards; and

23 “(C) identify duplication and overlap in
24 such existing standards;

1 and recommend new standards and modifications to
2 such existing standards as necessary.

3 “(4) LIMITATION.—The standards and time-
4 frame for adoption described in this section shall be
5 consistent with any standards developed pursuant to
6 the Health Insurance Portability and Accountability
7 Act of 1996.

8 “(e) FEDERAL ACTION.—Not later than 90 days
9 after the issuance of a recommendation from the Collabo-
10 rative under subsection (d)(2), the Secretary of Health
11 and Human Services, the Secretary of Veterans Affairs,
12 and the Secretary of Defense, in collaboration with rep-
13 resentatives of other relevant Federal agencies, as deter-
14 mined appropriate by the Secretary, shall jointly review
15 such recommendations. If appropriate, the Secretary shall
16 provide for the adoption by the Federal Government of
17 any standard or standards contained in such recommenda-
18 tion.

19 “(f) COORDINATION OF FEDERAL SPENDING.—

20 “(1) IN GENERAL.—Not later than 1 year after
21 the adoption by the Federal Government of a rec-
22 ommendation as provided for in subsection (e), and
23 in compliance with chapter 113 of title 40, United
24 States Code, no Federal agency shall expend Federal
25 funds for the purchase of any new health informa-

1 tion technology or health information technology sys-
2 tem for clinical care or for the electronic retrieval,
3 storage, or exchange of health information that is
4 not consistent with applicable standards adopted by
5 the Federal Government under subsection (e).

6 “(2) RULE OF CONSTRUCTION.—Nothing in
7 paragraph (1) shall be construed to restrict the pur-
8 chase of minor (as determined by the Secretary)
9 hardware or software components in order to mod-
10 ify, correct a deficiency in, or extend the life of exist-
11 ing hardware or software.

12 “(g) COORDINATION OF FEDERAL DATA COLLEC-
13 TION.—Not later than 3 years after the adoption by the
14 Federal Government of a recommendation as provided for
15 in subsection (e), all Federal agencies collecting health
16 data for the purposes of quality reporting, surveillance, ep-
17 idemiology, adverse event reporting, research, or for other
18 purposes determined appropriate by the Secretary, shall
19 comply with standards adopted under subsection (e).

20 “(h) VOLUNTARY ADOPTION.—

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

24 “(2) RULE OF CONSTRUCTION.—Nothing in
25 this section shall be construed to require that a pri-

1 vate entity that enters into a contract with the Fed-
2 eral Government adopt the standards adopted by the
3 Federal Government under this section with respect
4 to activities not related to the contract.

5 “(3) LIMITATION.—Private entities that enter
6 into a contract with the Federal Government shall
7 adopt the standards adopted by the Federal Govern-
8 ment under this section for the purpose of activities
9 under such Federal contract.

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

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

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

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

8 “(k) RULE OF CONSTRUCTION.—Nothing in this sec-
9 tion shall be construed to require the duplication of Fed-
10 eral efforts with respect to the establishment of the Col-
11 laborative, regardless of whether such efforts were carried
12 out prior to or after the enactment of this title.

18 **“SEC. 2904. IMPLEMENTATION AND CERTIFICATION OF**
19 **HEALTH INFORMATION STANDARDS.**

21 “(1) IN GENERAL.—The Secretary, based upon
22 the recommendations of the Collaborative, shall de-
23 velop criteria to ensure uniform and consistent im-
24 plementation of any standards for the electronic ex-
25 change of health information voluntarily adopted by

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

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

8 “(b) CERTIFICATION.—

9 “(1) IN GENERAL.—The Secretary, based upon
10 the recommendations of the Collaborative, shall de-
11 velop criteria to ensure and certify that hardware
12 and software that claim to be in compliance with ap-
13 plicable standards for the electronic exchange of
14 health information adopted under this title have es-
15 tablished and maintained such compliance in tech-
16 nical conformance with such standards.

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

22 “(c) OUTSIDE INVOLVEMENT.—The Secretary,
23 through consultation with the Collaborative, may accept
24 recommendations on the development of the criteria under

1 subsections (a) and (b) from a Federal agency or private
2 entity.

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

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

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

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

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

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

23 “(C) be a—

24 “(i) not for profit hospital, including a
25 federally qualified health center (as defined

1 in section 1861(aa)(4) of the Social Secu-
2 rity Act);

3 “(ii) individual or group practice; or

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

6 “(D) adopt the standards adopted by the
7 Federal Government under section 2903;

8 “(E) implement the measures adopted
9 under section 2907 and report to the Secretary
10 on such measures;

11 “(F) agree to notify patients if their indi-
12 vidually identifiable health information is
13 wrongfully disclosed;

14 “(G) demonstrate significant financial
15 need; and

16 “(H) provide matching funds in accord-
17 ance with paragraph (4).

18 “(3) USE OF FUNDS.—Amounts received under
19 a grant under this subsection shall be used to facili-
20 tate the purchase and enhance the utilization of
21 qualified health information technology systems and
22 training personnel in the use of such technology.

23 “(4) MATCHING REQUIREMENT.—To be eligible
24 for a grant under this subsection an entity shall con-
25 tribute non-Federal contributions to the costs of car-

1 rying out the activities for which the grant is award-
2 ed in an amount equal to \$1 for each \$3 of Federal
3 funds provided under the grant.

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

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

10 “(B) eligible entities that will link, to the
11 extent practicable, the qualified health informa-
12 tion system to local or regional health informa-
13 tion plan or plans; and

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

17 “(b) COMPETITIVE GRANTS TO STATES FOR THE DE-
18 VELOPMENT OF STATE LOAN PROGRAMS TO FACILITATE
19 THE WIDESPREAD ADOPTION OF HEALTH INFORMATION
20 TECHNOLOGY.—

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

1 “(2) ESTABLISHMENT OF FUND.—To be eligi-
2 ble to receive a competitive grant under this sub-
3 section, a State shall establish a qualified health in-
4 formation technology loan fund (referred to in this
5 subsection as a ‘State loan fund’) and comply with
6 the other requirements contained in this section. A
7 grant to a State under this subsection shall be de-
8 posited in the State loan fund established by the
9 State. No funds authorized by other provisions of
10 this title to be used for other purposes specified in
11 this title shall be deposited in any State loan fund.

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

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

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

20 “(C) establish a qualified health informa-
21 tion technology loan fund in accordance with
22 paragraph (2);

23 “(D) require that health care providers re-
24 ceiving such loans—

1 “(i) link, to the extent practicable, the
2 qualified health information system to a
3 local or regional health information net-
4 work;

5 “(ii) consult with the Health Informa-
6 tion Technology Resource Center estab-
7 lished in section 914(d) to access the
8 knowledge and experience of existing initia-
9 tives regarding the successful implementa-
10 tion and effective use of health information
11 technology; and

12 “(iii) agree to notify patients if their
13 individually identifiable health information
14 is wrongfully disclosed;

15 “(E) require that health care providers re-
16 ceiving such loans adopt the standards adopted
17 by the Federal Government under section 2903;

18 “(F) require that health care providers re-
19 ceiving such loans implement the measures
20 adopted under section 2907 and report to the
21 Secretary on such measures; and

22 “(G) provide matching funds in accordance
23 with paragraph (8).

24 “(4) STRATEGIC PLAN.—

1 “(A) IN GENERAL.—A State that receives
2 a grant under this subsection shall annually
3 prepare a strategic plan that identifies the in-
4 tended uses of amounts available to the State
5 loan fund of the State.

6 “(B) CONTENTS.—A strategic plan under
7 subparagraph (A) shall include—

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

12 “(ii) a description of the criteria and
13 methods established for the distribution of
14 funds from the State loan fund; and

15 “(iii) a description of the financial
16 status of the State loan fund and the
17 short-term and long-term goals of the
18 State loan fund.

19 “(5) USE OF FUNDS.—

20 “(A) IN GENERAL.—Amounts deposited in
21 a State loan fund, including loan repayments
22 and interest earned on such amounts, shall be
23 used only for awarding loans or loan guaran-
24 tees, or as a source of reserve and security for
25 leveraged loans, the proceeds of which are de-

1 posited in the State loan fund established under
2 paragraph (1). Loans under this section may be
3 used by a health care provider to facilitate the
4 purchase and enhance the utilization of quali-
5 fied health information technology and training
6 of personnel in the use of such technology.

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

9 “(i) for the purchase or other acquisi-
10 tion of any health information technology
11 system that is not a qualified health infor-
12 mation technology system;

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

17 “(iii) for any purpose other than mak-
18 ing loans to eligible entities under this sec-
19 tion.

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

24 “(A) To award loans that comply with the
25 following:

1 “(i) The interest rate for each loan
2 shall be less than or equal to the market
3 interest rate.

4 “(ii) The principal and interest pay-
5 ments on each loan shall commence not
6 later than 1 year after the loan was award-
7 ed, and each loan shall be fully amortized
8 not later than 10 years after the date of
9 the loan.

10 “(iii) The State loan fund shall be
11 credited with all payments of principal and
12 interest on each loan awarded from the
13 fund.

14 “(B) To guarantee, or purchase insurance
15 for, a local obligation (all of the proceeds of
16 which finance a project eligible for assistance
17 under this subsection) if the guarantee or pur-
18 chase would improve credit market access or re-
19 duce the interest rate applicable to the obliga-
20 tion involved.

21 “(C) As a source of revenue or security for
22 the payment of principal and interest on rev-
23 enue or general obligation bonds issued by the
24 State if the proceeds of the sale of the bonds
25 will be deposited into the State loan fund.

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

3 “(7) ADMINISTRATION OF STATE LOAN
4 FUNDS.—

5 “(A) COMBINED FINANCIAL ADMINISTRA-
6 TION.—A State may (as a convenience and to
7 avoid unnecessary administrative costs) com-
8 bine, in accordance with State law, the financial
9 administration of a State loan fund established
10 under this subsection with the financial admin-
11 istration of any other revolving fund established
12 by the State if otherwise not prohibited by the
13 law under which the State loan fund was estab-
14 lished.

15 “(B) COST OF ADMINISTERING FUND.—
16 Each State may annually use not to exceed 4
17 percent of the funds provided to the State
18 under a grant under this subsection to pay the
19 reasonable costs of the administration of the
20 programs under this section, including the re-
21 covery of reasonable costs expended to establish
22 a State loan fund which are incurred after the
23 date of enactment of this title.

24 “(C) GUIDANCE AND REGULATIONS.—The
25 Secretary shall publish guidance and promul-

1 gate regulations as may be necessary to carry
2 out the provisions of this subsection, includ-
3 ing—

4 “(i) provisions to ensure that each
5 State commits and expends funds allotted
6 to the State under this subsection as effi-
7 ciently as possible in accordance with this
8 title and applicable State laws; and

9 “(ii) guidance to prevent waste, fraud,
10 and abuse.

11 “(D) PRIVATE SECTOR CONTRIBUTIONS.—

12 “(i) IN GENERAL.—A State loan fund
13 established under this subsection may ac-
14 cept contributions from private sector enti-
15 ties, except that such entities may not
16 specify the recipient or recipients of any
17 loan issued under this subsection.

18 “(ii) AVAILABILITY OF INFORMA-
19 TION.—A State shall make publicly avail-
20 able the identity of, and amount contrib-
21 uted by, any private sector entity under
22 clause (i) and may issue letters of com-
23 mendation or make other awards (that
24 have no financial value) to any such entity.

25 “(8) MATCHING REQUIREMENTS.—

1 “(A) IN GENERAL.—The Secretary may
2 not make a grant under paragraph (1) to a
3 State unless the State agrees to make available
4 (directly or through donations from public or
5 private entities) non-Federal contributions in
6 cash toward the costs of the State program to
7 be implemented under the grant in an amount
8 equal to not less than \$1 for each \$1 of Federal
9 funds provided under the grant.

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

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

22 “(10) REPORTS.—The Secretary shall annually
23 submit to the Committee on Health, Education,
24 Labor, and Pensions and the Committee on Finance
25 of the Senate, and the Committee on Energy and

1 Commerce and the Committee on Ways and Means
2 of the House of Representatives, a report summa-
3 rizing the reports received by the Secretary from
4 each State that receives a grant under this sub-
5 section.

6 “(c) COMPETITIVE GRANTS FOR THE IMPLEMENTA-
7 TION OF REGIONAL OR LOCAL HEALTH INFORMATION
8 TECHNOLOGY PLANS.—

9 “(1) IN GENERAL.—The Secretary may award
10 competitive grants to eligible entities to implement
11 regional or local health information plans to improve
12 health care quality and efficiency through the elec-
13 tronic exchange of health information pursuant to
14 the standards, protocols, and other requirements
15 adopted by the Secretary under sections 2903 and
16 2907.

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

19 “(A) demonstrate financial need to the
20 Secretary;

21 “(B) demonstrate that one of its principal
22 missions or purposes is to use information tech-
23 nology to improve health care quality and effi-
24 ciency;

1 “(C) adopt bylaws, memoranda of under-
2 standing, or other charter documents that dem-
3 onstrate that the governance structure and de-
4 cisionmaking processes of such entity allow for
5 participation on an ongoing basis by multiple
6 stakeholders within a community, including—

7 “(i) physicians (as defined in section
8 1861(r) of the Social Security Act), includ-
9 ing physicians that provide services to low
10 income and underserved populations;

11 “(ii) hospitals (including hospitals
12 that provide services to low income and un-
13 derserved populations);

14 “(iii) pharmacists or pharmacies;

15 “(iv) health insurance plans;

16 “(v) health centers (as defined in sec-
17 tion 330(b)) and Federally qualified health
18 centers (as defined in section 1861(aa)(4)
19 of the Social Security Act);

20 “(vi) rural health clinics (as defined in
21 section 1861(aa) of the Social Security
22 Act);

23 “(vii) patient or consumer organiza-
24 tions;

25 “(viii) employers; and

1 “(ix) any other health care providers
2 or other entities, as determined appro-
3 priate by the Secretary;

4 “(D) demonstrate the participation, to the
5 extent practicable, of stakeholders in the elec-
6 tronic exchange of health information within
7 the local or regional plan pursuant to para-
8 graph (2)(C);

9 “(E) adopt nondiscrimination and conflict
10 of interest policies that demonstrate a commit-
11 ment to open, fair, and nondiscriminatory par-
12 ticipation in the health information plan by all
13 stakeholders;

14 “(F) adopt the standards adopted by the
15 Secretary under section 2903;

16 “(G) require that health care providers re-
17 ceiving such grants implement the measures
18 adopted under section 2907 and report to the
19 Secretary on such measures;

20 “(H) agree to notify patients if their indi-
21 vidually identifiable health information is
22 wrongfully disclosed;

23 “(I) facilitate the electronic exchange of
24 health information within the local or regional
25 area and among local and regional areas;

1 “(J) prepare and submit to the Secretary
2 an application in accordance with paragraph
3 (3); and

4 “(K) agree to provide matching funds in
5 accordance with paragraph (5).

6 “(3) APPLICATION.—

7 “(A) IN GENERAL.—To be eligible to re-
8 ceive a grant under paragraph (1), an entity
9 shall submit to the Secretary an application at
10 such time, in such manner, and containing such
11 information as the Secretary may require.

12 “(B) REQUIRED INFORMATION.—At a
13 minimum, an application submitted under this
14 paragraph shall include—

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

18 “(ii) a technology plan that complies
19 with the standards adopted under section
20 2903 and that includes a descriptive and
21 reasoned estimate of costs of the hardware,
22 software, training, and consulting services
23 necessary to implement the regional or
24 local health information plan;

1 “(iii) a strategy that includes initia-
2 tives to improve health care quality and ef-
3 ficiency, including the use and reporting of
4 health care quality measures adopted
5 under section 2907;

6 “(iv) a plan that describes provisions
7 to encourage the implementation of the
8 electronic exchange of health information
9 by all physicians, including single physician
10 practices and small physician groups par-
11 ticipating in the health information plan;

12 “(v) a plan to ensure the privacy and
13 security of personal health information
14 that is consistent with Federal and State
15 law;

16 “(vi) a governance plan that defines
17 the manner in which the stakeholders shall
18 jointly make policy and operational deci-
19 sions on an ongoing basis;

20 “(vii) a financial or business plan that
21 describes—

22 “(I) the sustainability of the
23 plan;

24 “(II) the financial costs and ben-
25 efits of the plan; and

1 “(III) the entities to which such
2 costs and benefits will accrue; and

3 “(viii) in the case of an applicant enti-
4 ty that is unable to demonstrate the par-
5 ticipation of all stakeholders pursuant to
6 paragraph (2)(C), the justification from
7 the entity for any such nonparticipation.

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

12 “(5) MATCHING REQUIREMENT.—

13 “(A) IN GENERAL.—The Secretary may
14 not make a grant under this subsection to an
15 entity unless the entity agrees that, with re-
16 spect to the costs to be incurred by the entity
17 in carrying out the infrastructure program for
18 which the grant was awarded, the entity will
19 make available (directly or through donations
20 from public or private entities) non-Federal
21 contributions toward such costs in an amount
22 equal to not less than 50 percent of such costs
23 (\$1 for each \$2 of Federal funds provided
24 under the grant).

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

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

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

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

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

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

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

6 “(e) REQUIREMENT TO ACHIEVE QUALITY IMPROVE-
7 MENT.—The Secretary shall annually evaluate the activi-
8 ties conducted under this section and shall, in awarding
9 grants, implement the lessons learned from such evalua-
10 tion in a manner so that awards made subsequent to each
11 such evaluation are made in a manner that, in the deter-
12 mination of the Secretary, will result in the greatest im-
13 provement in quality measures under section 2907.

14 “(f) LIMITATION.—An eligible entity may only receive
15 one non-renewable grant under subsection (a), one non-
16 renewable grant under subsection (b), and one non-renew-
17 able grant under subsection (c).

18 “(g) AUTHORIZATION OF APPROPRIATIONS.—

19 “(1) IN GENERAL.—For the purpose of car-
20 rying out this section, there is authorized to be ap-
21 propriated \$116,000,000 for fiscal year 2006,
22 \$141,000,000 for fiscal year 2007, and such sums
23 as may be necessary for each of fiscal years 2008
24 through 2010.

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

4 **“SEC. 2906. DEMONSTRATION PROGRAM TO INTEGRATE IN-**
5 **FORMATION TECHNOLOGY INTO CLINICAL**
6 **EDUCATION.**

7 “(a) IN GENERAL.—The Secretary may award grants
8 under this section to carry out demonstration projects to
9 develop academic curricula integrating qualified health in-
10 formation technology systems in the clinical education of
11 health professionals. Such awards shall be made on a com-
12 petitive basis and pursuant to peer review.

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

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

18 “(2) submit to the Secretary a strategic plan
19 for integrating qualified health information tech-
20 nology in the clinical education of health profes-
21 sionals and for ensuring the consistent utilization of
22 decision support software to reduce medical errors
23 and enhance health care quality;

24 “(3) be—

25 “(A) a health professions school;

1 “(B) a school of nursing; or

2 “(C) an institution with a graduate med-
3 ical education program;

4 “(4) provide for the collection of data regarding
5 the effectiveness of the demonstration project to be
6 funded under the grant in improving the safety of
7 patients, the efficiency of health care delivery, and
8 in increasing the likelihood that graduates of the
9 grantee will adopt and incorporate health informa-
10 tion technology, and implement the quality measures
11 adopted under section 2907, in the delivery of health
12 care services; and

13 “(5) provide matching funds in accordance with
14 subsection (c).

15 “(c) USE OF FUNDS.—

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

18 “(A) use grant funds in collaboration with
19 2 or more disciplines; and

20 “(B) use grant funds to integrate qualified
21 health information technology into community-
22 based clinical education.

23 “(2) LIMITATION.—An eligible entity shall not
24 use amounts received under a grant under sub-

1 section (a) to purchase hardware, software, or serv-
2 ices.

3 “(d) MATCHING FUNDS.—

4 “(1) IN GENERAL.—The Secretary may award
5 a grant to an entity under this section only if the
6 entity agrees to make available non-Federal con-
7 tributions toward the costs of the program to be
8 funded under the grant in an amount that is not
9 less than \$1 for each \$2 of Federal funds provided
10 under the grant.

11 “(2) DETERMINATION OF AMOUNT CONTRIB-
12 UTED.—Non-Federal contributions under paragraph
13 (1) may be in cash or in kind, fairly evaluated, in-
14 cluding equipment or services. Amounts provided by
15 the Federal Government, or services assisted or sub-
16 sidized to any significant extent by the Federal Gov-
17 ernment, may not be included in determining the
18 amount of such contributions.

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

24 “(f) REPORTS.—Not later than 1 year after the date
25 of enactment of this title, and annually thereafter, the Sec-

1 retary shall submit to the Committee on Health, Edu-
2 cation, Labor, and Pensions and the Committee on Fi-
3 nance of the Senate, and the Committee on Energy and
4 Commerce and the Committee on Ways and Means of the
5 House of Representatives a report that—

6 “(1) describes the specific projects established
7 under this section; and

8 “(2) contains recommendations for Congress
9 based on the evaluation conducted under subsection
10 (e).

11 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
12 is authorized to be appropriated to carry out this section,
13 \$5,000,000 for fiscal year 2007, and such sums as may
14 be necessary for each of fiscal years 2008 through 2010.

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

17 **“SEC. 2907. QUALITY MEASURES.**

18 “(a) IN GENERAL.—The Secretary shall develop
19 quality measures, including measures to assess the effec-
20 tiveness, timeliness, patient self-management, patient
21 centeredness, efficiency, and safety, for the purpose of
22 measuring the quality of care patients receive.

23 “(b) REQUIREMENTS.—The Secretary shall ensure
24 that the quality measures developed under this section
25 comply with the following:

1 “(1) MEASURES.—

2 “(A) REQUIREMENTS.—In developing the
3 quality measures under this section, the Sec-
4 retary shall, to the extent feasible, ensure
5 that—

6 “(i) such measures are evidence
7 based, reliable, and valid;

8 “(ii) such measures are consistent
9 with the purposes described in section
10 2902(b);

11 “(iii) such measures include measures
12 of clinical processes and outcomes, patient
13 experience, efficiency, and equity; and

14 “(iv) such measures include measures
15 of overuse and underuse of health care
16 items and services.

17 “(2) PRIORITIES.—In developing the quality
18 measures under this section, the Secretary shall en-
19 sure that priority is given to—

20 “(A) measures with the greatest potential
21 impact for improving the quality and efficiency
22 of care provided under this Act;

23 “(B) measures that may be rapidly imple-
24 mented by group health plans, health insurance
25 issuers, physicians, hospitals, nursing homes,

1 long-term care providers, and other providers;
2 and

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

5 “(3) RISK ADJUSTMENT.—The Secretary shall
6 establish procedures to account for differences in pa-
7 tient health status, patient characteristics, and geo-
8 graphic location. To the extent practicable, such pro-
9 cedures shall recognize existing procedures.

10 “(4) MAINTENANCE.—The Secretary shall, as
11 determined appropriate, but in no case more often
12 than once during each 12-month period, update the
13 quality measures, including through the addition of
14 more accurate and precise measures and the retire-
15 ment of existing outdated measures.

16 “(5) RELATIONSHIP WITH PROGRAMS UNDER
17 THE SOCIAL SECURITY ACT.—The Secretary shall
18 ensure that the quality measures developed under
19 this section—

20 “(A) complement quality measures devel-
21 oped by the Secretary under programs adminis-
22 tered by the Secretary under the Social Security
23 Act, including programs under titles XVIII,
24 XIX, and XXI of such Act; and

1 “(B) do not conflict with the needs and
2 priorities of the programs under titles XVIII,
3 XIX, and XXI of such Act, as set forth by the
4 Administrator of the Centers for Medicare &
5 Medicaid Services.

6 “(c) REQUIRED CONSIDERATIONS IN DEVELOPING
7 AND UPDATING THE MEASURES.—In developing and up-
8 dating the quality measures under this section, the Sec-
9 retary may take into account—

10 “(1) any demonstration or pilot program con-
11 ducted by the Secretary relating to measuring and
12 rewarding quality and efficiency of care;

13 “(2) any existing activities conducted by the
14 Secretary relating to measuring and rewarding qual-
15 ity and efficiency;

16 “(3) any existing activities conducted by private
17 entities, including health insurance plans and
18 payors;

19 “(4) the report by the Institute of Medicine of
20 the National Academy of Sciences under section
21 238(b) of the Medicare Prescription Drug, Improve-
22 ment, and Modernization Act of 2003; and

23 “(5) issues of data collection and reporting, in-
24 cluding the feasibility of collecting and reporting
25 data on measures.

1 “(d) SOLICITATION OF ADVICE AND RECOMMENDA-
2 TIONS.—On and after July 1, 2006, the Secretary shall
3 consult with the following regarding the development, up-
4 dating, and use of quality measures developed under this
5 section:

6 “(1) Health insurance plans and health care
7 providers, including such plans and providers with
8 experience in the care of the frail elderly and indi-
9 viduals with multiple complex chronic conditions, or
10 groups representing such health insurance plans and
11 providers.

12 “(2) Groups representing patients and con-
13 sumers.

14 “(3) Purchasers and employers or groups rep-
15 resenting purchasers or employers.

16 “(4) Organizations that focus on quality im-
17 provement as well as the measurement and reporting
18 of quality measures.

19 “(5) Organizations that certify and license
20 health care providers.

21 “(6) State government public health programs.

22 “(7) Individuals or entities skilled in the con-
23 duct and interpretation of biomedical, health serv-
24 ices, and health economics research and with exper-

1 tise in outcomes and effectiveness research and tech-
2 nology assessment.

3 “(8) Individuals or entities involved in the de-
4 velopment and establishment of standards and cer-
5 tification for health information technology systems
6 and clinical data.

7 “(9) Individuals or entities with experience
8 with—

9 “(A) urban health care issues;

10 “(B) safety net health care issues; and

11 “(C) rural and frontier health care issues.

12 “(e) USE OF QUALITY MEASURES.—

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

18 “(2) COLLABORATIVE AGREEMENTS.—With re-
19 spect to activities conducted or supported by the
20 Secretary under this Act, the Secretary may estab-
21 lish collaborative agreements with private entities,
22 including group health plans and health insurance
23 issuers, providers, purchasers, consumer organiza-
24 tions, and entities receiving a grant under section
25 2905, to—

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

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

7 “(3) REPORTING.—The Secretary shall imple-
8 ment procedures to enable the Department of
9 Health and Human Services to accept the electronic
10 submission of data for purposes of—

11 “(A) quality measurement using the qual-
12 ity measures developed under this section and
13 using the standards adopted by the Federal
14 Government under section 2903; and

15 “(B) for reporting measures used to make
16 value-based payments under programs under
17 the Social Security Act.

18 “(f) DISSEMINATION OF INFORMATION.—Beginning
19 on January 1, 2008, in order to make comparative quality
20 information available to health care consumers, health
21 professionals, public health officials, researchers, and
22 other appropriate individuals and entities, the Secretary
23 shall provide for the dissemination, aggregation, and anal-
24 ysis of quality measures collected under section 2905 and

1 the dissemination of recommendations and best practices
2 derived in part from such analysis.

3 “(g) TECHNICAL ASSISTANCE.—The Secretary shall
4 provide technical assistance to public and private entities
5 to enable such entities to—

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

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

13 “(h) RULE OF CONSTRUCTION.—Nothing in this title
14 shall be construed as prohibiting the Secretary, acting
15 through the Administrator of the Centers for Medicare &
16 Medicaid Services, from developing quality measures (and
17 timing requirements for reporting such measures) for use
18 under programs administered by the Secretary under the
19 Social Security Act, including programs under titles
20 XVIII, XIX, and XXI of such Act.”.

21 **SEC. 3. LICENSURE AND THE ELECTRONIC EXCHANGE OF**
22 **HEALTH INFORMATION.**

23 (a) IN GENERAL.—The Secretary of Health and
24 Human Services shall carry out, or contract with a private
25 entity to carry out, a study that examines—

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

4 (2) how such variation among State laws im-
5 pacts the secure electronic exchange of health infor-
6 mation—

7 (A) among the States; and

8 (B) between the States and the Federal
9 Government.

10 (b) REPORT AND RECOMMENDATIONS.—Not later
11 than 1 year after the date of enactment of this Act, the
12 Secretary of Health and Human Services shall publish a
13 report that—

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

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

19 **SEC. 4. ENSURING PRIVACY AND SECURITY.**

20 Nothing in this Act (or the amendments made by this
21 Act) shall be construed to affect the scope, substance, or
22 applicability of—

23 (1) section 264 of the Health Insurance Port-
24 ability and Accountability Act of 1996;

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

3 (3) any regulation issued pursuant to any such
4 section.

5 **SEC. 5. GAO STUDY.**

6 Not later than 6 months after the date of enactment
7 of this Act, the Comptroller General of the United States
8 shall submit to Congress a report on the necessity and
9 workability of requiring health plans (as defined in section
10 1171 of the Social Security Act (42 U.S.C. 1320d)),
11 health care clearinghouses (as defined in such section
12 1171), and health care providers (as defined in such sec-
13 tion 1171) who transmit health information in electronic
14 form, to notify patients if their individually identifiable
15 health information (as defined in such section 1171) is
16 wrongfully disclosed.

17 **SEC. 6. STUDY OF REIMBURSEMENT INCENTIVES.**

18 The Secretary of Health and Human Services shall
19 carry out, or contract with a private entity to carry out,
20 a study that examines methods to create efficient reim-
21 bursement incentives for improving health care quality in
22 Federally qualified health centers, rural health clinics, and
23 free clinics.

1 **SEC. 7. HEALTH INFORMATION TECHNOLOGY RESOURCE**
2 **CENTER.**

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

6 “(d) HEALTH INFORMATION TECHNOLOGY RE-
7 SOURCE CENTER.—

8 “(1) IN GENERAL.—The Secretary, acting
9 through the Director, shall develop a Health Infor-
10 mation Technology Resource Center to provide tech-
11 nical assistance and develop best practices to sup-
12 port and accelerate efforts to adopt, implement, and
13 effectively use interoperable health information tech-
14 nology in compliance with section 2903 and 2907.

15 “(2) PURPOSES.—The purpose of the Center is
16 to—

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

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

23 “(C) assemble, analyze, and widely dis-
24 seminate evidence and experience related to the
25 adoption, implementation, and effective use of
26 interoperable health information technology;

1 “(D) provide for the establishment of re-
2 gional and local health information networks to
3 facilitate the development of interoperability
4 across health care settings and improve the
5 quality of health care;

6 “(E) provide for the development of solu-
7 tions to barriers to the exchange of electronic
8 health information; and

9 “(F) conduct other activities identified by
10 the States, local or regional health information
11 networks, or health care stakeholders as a focus
12 for developing and sharing best practices.

13 “(3) SUPPORT FOR ACTIVITIES.—To provide
14 support for the activities of the Center, the Director
15 shall modify the requirements, if necessary, that
16 apply to the National Resource Center for Health
17 Information Technology to provide the necessary in-
18 frastructure to support the duties and activities of
19 the Center and facilitate information exchange
20 across the public and private sectors.

21 “(4) RULE OF CONSTRUCTION.—Nothing in
22 this subsection shall be construed to require the du-
23 plication of Federal efforts with respect to the estab-
24 lishment of the Center, regardless of whether such

1 efforts were carried out prior to or after the enact-
2 ment of this subsection.

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

8 “(1) learn about Federal grants and technical
9 assistance services related to interoperable health in-
10 formation technology;

11 “(2) learn about qualified health information
12 technology and the quality measures adopted by the
13 Federal Government under sections 2903 and 2907;

14 “(3) learn about regional and local health infor-
15 mation networks for assistance with health informa-
16 tion technology; and

17 “(4) disseminate additional information deter-
18 mined by the Secretary.

19 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
20 is authorized to be appropriated, such sums as may be
21 necessary for each of fiscal years 2006 and 2007 to carry
22 out this subsection.”.

1 **SEC. 8. REAUTHORIZATION OF INCENTIVE GRANTS RE-**
2 **GARDING TELEMEDICINE.**

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

○