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110TH CONGRESS
1ST SESSION

H. R. 1952

To amend title XI of the Social Security Act to achieve a national health information infrastructure, and to amend the Internal Revenue Code of 1986 to increase the deduction under section 179 for the purchase of qualified health care information technology by medical care providers.

IN THE HOUSE OF REPRESENTATIVES

APRIL 19, 2007

Mr. GONZALEZ (for himself, Mr. GINGREY, Ms. VELÁZQUEZ, and Mr. GENE GREEN of Texas) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title XI of the Social Security Act to achieve a national health information infrastructure, and to amend the Internal Revenue Code of 1986 to increase the deduction under section 179 for the purchase of qualified health care information technology by medical care providers.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as ''National Health Information Incentive Act of 2007''.

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—The Congress finds as follows:

(1) A March 2001 Institute of Medicine (''IOM'') study concludes that in order to improve quality, the nation must have a national commitment to building an information infrastructure to support healthcare delivery, consumer health, quality measurement and improvement, public accountability, clinical and health services research, and clinical education.

(2) A November 2001 National Committee on Vital Health Statistics study lauds the importance of a national health information infrastructure to improve patient safety, improve healthcare quality, improve bioterrorism detection, better inform and empower healthcare consumers regarding their own personal health information, and to better understand healthcare costs.

(3) An October 2002 IOM report calls on the federal government to take steps to encourage and facilitate development in the information technology infrastructure that is critical to healthcare quality and safety enhancement.

(4) A General Accounting Office October 2003 report found that the benefits of an electronic healthcare information system included improved quality of care, reduced costs associated with medication errors, more accurate and complete medical documentation, more accurate capture of codes and charges, and improved communication among providers enabling them to respond more quickly to patients' needs.

(5) Other more recent studies and surveys show that cultivating a national healthcare information infrastructure and improving patient care will depend crucially on adoption of uniform medical data standards and interoperability.

(6) The ability of physicians to deliver patient-centered care to patients, particularly those with multiple chronic illnesses, will depend on having the electronic systems in place at the practice level to enable them to track patients by disease conditions, to have access to evidence-based clinical decision support tools at the point of care, to share information with patients and other health care professionals, and to track, measure and report on the qualify of care provided.

(7) A Commonwealth Fund survey of physicians found that there is a gap between physicians' support for and willingness to provide such patient-centered services and having the electronic systems in place to enable them to do, with the costs of acquiring and maintaining such systems being identified as a major barrier.

(8) Acquisition costs, physician and staff time required to transition from paper-based offices to electronic health systems, and the lack of industry standards on interoperability are the principle barriers to creating a national health information infrastructure.

(9) The success of a national health information infrastructure depends on the widespread use and acceptance of electronic health records and other health information technologies in physician offices.

(b) PURPOSES.—The purposes of this Act are as follows:

(1) To create incentives that encourage physicians and other health professionals to adopt interoperable electronic health records, electronic prescribing systems, evidence-based clinical decision tools, remote monitoring, patient registries, secure

email, and other health information technology as a key component of a national health care information infrastructure in the United States to ensure the rapid flow of secure, private and digitized information relevant to all facets of patient care.

(2) To do so in a voluntary manner that does not become an unfunded mandate on small physician practices.

(3) To do so in a manner that does not compromise the medical care provider's ability to make patient care decisions based solely on his or her clinical expertise and experience, and what the provider and patient concludes is the best for a particular patient based upon scientific evidence and knowledge of the patient's medical history.

SEC. 3. OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY.

(a) ESTABLISHMENT.—There is established within the Office of the Secretary of Health and Human Services an Office of the National Coordinator for Health Information Technology. The Office shall be headed by a National Coordinator appointed by the President, in consultation with the Secretary of Health and Human Services. The National Coordinator shall report directly to the Secretary.

(b) RESOURCES.—The President shall make available to the Office of the National Coordinator for Health Information Technology the resources, both financial and otherwise, necessary to enable the National Coordinator to carry out the purposes of, and perform the duties and responsibilities of, the Office.

SEC. 4. BUILDING THE NATIONAL HEALTH INFORMATION INFRASTRUCTURE.

Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following part:

''PART D—BUILDING THE NATIONAL HEALTH INFORMATION INFRASTRUCTURE

''FINANCIAL INCENTIVE TO SMALL MEDICAL CARE PROVIDERS AND ENTITIES TO IMPLEMENT A NATIONAL HEALTH INFORMATION INFRASTRUCTURE

''SEC. 1181. (a) IN GENERAL.—The Secretary shall include additional Medicare payment incentives to assure small medical care providers have the capability to move toward a national health care information infrastructure by acquiring electronic health record systems and other health information technologies.

''(b) CONDITIONS FOR QUALIFICATION.—As a condition of qualifying for financial incentives described in this section, the Secretary shall grant the use of financial in-

centives to assure that such technologies are consistent with the goals of creation of a national health information infrastructure, such as—

''(1) voluntary participation in studies or demonstration projects to evaluate the use of such systems to measure and report quality data based on accepted clinical performance measures;

''(2) voluntary participation in studies to demonstrate the impact of such technologies on improving patient care, reducing costs and increasing efficiencies; and

''(3) voluntary participation in studies and demonstration projects on providing patient-centered care coordinated by a patient's personal physician (as defined by the Institute of Medicine), using electronic systems that enable and facilitate care coordination and sharing of information among the physician and other treating health care professionals, family caregivers, and the patient.

''(c) ADDITIONAL MEDICARE PAYMENT TO SMALL MEDICAL CARE PROVIDERS AND ENTITIES FOR EXPENDITURES RELATING TO THE IMPLEMENTATION OF PRACTICE-BASED ELECTRONIC SYSTEMS THAT WILL SERVE AS THE FOUNDATION FOR A NATIONAL HEALTH INFORMATION INFRASTRUCTURE.—

''(1) IN GENERAL.—The Secretary shall provide for additional payment to medical care providers in small practice settings, including physicians and others in clinical practice, for the purpose of assisting such entities to acquire and adopt patient registries, evidence-based clinical decision support tools at the point of care, electronic health records, secure email, and other health information technologies defined by the Secretary as a key component of a national health care information infrastructure.

''(2) TYPES OF REIMBURSEMENT INCENTIVES.—In developing the reimbursement incentives described in paragraph (1), the Secretary shall consider inclusion of one or more of the following types of incentives:

''(A) Adds-ons to payments for evaluation and management services.

''(B) Care management fees that include an allowance for the costs associated with acquiring the electronic systems associated with providing coordinated and patient-centered care to beneficiaries, especially those with multiple chronic illnesses, as determined by the Secretary and that is included in the top 5 percent of claims (determined on the basis of cost).

"(C) Payments for structured e-mail consults and other technologies that will facilitate care coordination that are separately identifiable medical services from other evaluation and management services.

"(D) Any other method deemed appropriate by the Secretary to encourage participation.

"(3) AMOUNT OF REIMBURSEMENT.—The amount of reimbursement made to small medical care providers and entities to implement a national health care information infrastructure shall be in a manner determined by the Secretary that takes into account the costs of implementation, training, and complying with applicable standards. Such reimbursement amounts shall be calculated on a sliding scale, in a manner determined by the Secretary, to reward qualifying practices using more functional and comprehensive health information systems that meet the certification guidelines under paragraph (4) based on the following weighted-structure:

"(A) BASIC.—The maintenance of patient registries for the purpose of identifying and following up with at-risk patients and for the provision of educational resources to patients.

"(B) INTERMEDIATE.—In addition to complying with subparagraph (A), the use of three or more of the following:

"(i) An electronic systems to maintain patient records (EHRs).

"(ii) Clinical-decision support tools.

"(iii) Electronic order for prescriptions and lab tests (e-prescribing).

"(iv) Patient reminders.

"(v) E-consults (communication between patient-physician or other provider) when an identifiable medical service is provided.

"(vi) Managing patients with multiple chronic illnesses.

"(C) ADVANCED.—In addition to complying with subparagraphs (A) and (B), the use by a practice of an electronic system that—

"(i) is interconnected and is interoperable with other electronic systems;

"(ii) uses nationally accepted medical code sets; and

"(iii) can automatically send, receive, and integrate data, such as lab results and

medical histories, from other organizations' systems.

''(4) CERTIFICATION OF TECHNOLOGY.—The technology used under paragraph (3) must meet such guidelines for functionality as may be developed by the Secretary. In the case of technology for electronic health records (EHRs), technology that has been certified by the Certification Commission for Healthcare Information Technology (CCHIT) shall be considered as having met such guidelines.

''(5) EXEMPTION FROM BUDGET NEUTRALITY UNDER THE PHYSICIAN FEE SCHEDULE.—Any increased expenditures pursuant to this section shall be treated as additional allowed expenditures for purposes of computing any update under section 1848(d).

''(d) SMALL MEDICARE CARE PROVIDER DEFINED.—In this part, the term 'small medical care provider' means a medical care provider (as defined in section 179(e)(2)(B) of the Internal Revenue Code of 1986) that has an average of 10 or fewer full-time equivalent employees during the period involved.

''OPTIONAL FINANCIAL INCENTIVES TO SMALL MEDICAL CARE PROVIDERS AND ENTITIES TO IMPLEMENT A NATIONAL HEALTH INFORMATION INFRASTRUCTURE

''SEC. 1182. (a) IN GENERAL.—The Secretary may utilize any, all, or a combination of financial incentives thereof, to assure small medical care providers have the capability to move toward a national health care information infrastructure by acquiring electronic health record systems and other health information technologies that meet the standards adopted or modified by the Secretary.

''(b) CONDITIONS FOR QUALIFICATION.—As a condition of qualifying for financial incentives described in this section, the Secretary shall grant the use of financial incentives to assure that such technologies are consistent with the goals of creation of a national health information infrastructure, such as—

''(1) voluntary participation in studies or demonstration projects to evaluate the use of such systems to measure and report quality data based on accepted clinical performance measures;

''(2) voluntary participation in studies to demonstrate the impact of such technologies on improving patient care, reducing costs and increasing efficiencies; and

''(3) voluntary participation in studies and demonstration projects on providing patient-centered care coordinated by a patient's personal physician (as defined by the Institute of Medicine), using electronic systems that enable and facilitate care coordination and sharing of information among the physician and other treating health care professionals, family caregivers, and the patient.

''(c) GRANTS TO SMALL MEDICAL CARE PROVIDERS AND ENTITIES FOR EXPENDITURES RELATING TO THE IMPLEMENTATION OF A NATIONAL HEALTH INFORMATION INFRASTRUCTURE.—

''(1) IN GENERAL.—The Secretary is authorized to make grants to small medical care providers, including physicians and others in clinical practice, for the purpose of assisting such entities to acquire and adopt patient registries, evidence-based clinical decision support tools at the point of care, electronic health records, secure email, and other health information technologies defined by the Secretary as a key component of a national health care information infrastructure.

''(2) AMOUNT OF GRANT.—The grant amount made to small medical care providers and entities to implement a national health care information infra-

structure shall be in a manner determined by the Secretary that takes into account the costs of implementation, training, and complying with applicable standards.

''(3) APPLICATION.—No grant may be made under this subsection except pursuant to a grant application that is submitted in a time, manner, and form approved by the Secretary.

''(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection such sums as may be necessary for each fiscal year.

''(d) REVOLVING LOANS TO SMALL MEDICAL CARE PROVIDERS AND ENTITIES FOR EXPENDITURES RELATING TO THE IMPLEMENTATION OF A NATIONAL HEALTH INFORMATION INFRASTRUCTURE.—

''(1) IN GENERAL.—The Secretary is authorized to make and guarantee loans to small medical care providers, including physicians and others in clinical practice, for the purpose of assisting such entities to acquire and adopt patient registries, evidence-based clinical decision support tools at the point of care, electronic health records, secure email, and other health information technologies defined by the Sec-

retary as a key component of a national health care information infrastructure.

''(2) AMOUNT OF LOAN.—The loan amount made to small medical care providers and entities to implement a national health care information infrastructure shall be in a manner determined by the Secretary that takes into account the costs of implementation, training, and complying with standards.

''(3) APPLICATION.—No loan may be made under this subsection except pursuant to a loan application that is submitted in a time, manner, and form approved by the Secretary.

''(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection such sums as may be necessary for each fiscal year.''.

SEC. 5. ELECTION TO EXPENSE QUALIFIED HEALTH CARE INFORMATION TECHNOLOGY.

(a) IN GENERAL.—Section 179 of the Internal Revenue Code of 1986 (relating to election to expense certain depreciable assets) is amended by adding at the end the following new subsection:

''(e) HEALTH CARE INFORMATION TECHNOLOGY.—

''(1) IN GENERAL.—In the case of qualified health care information technology purchased by a

medical care provider and placed in service during a taxable year—

"(A) subsection (b)(1) shall be applied by substituting '$250,000' for '$100,000',

"(B) subsection (b)(2) shall be applied by substituting '$600,000' for '$400,000', and

"(C) subsection (b)(5)(A) shall be applied by substituting '$250,000 and $600,000' for '$100,000 and $400,000'.

"(2) DEFINITIONS.—For purposes of this subsection—

"(A) QUALIFIED HEALTH CARE INFORMATION TECHNOLOGY.—The term 'qualified health care information technology' means section 179 property which—

"(i) meets such guidelines for functionality as may be developed by the Secretary of Health and Human Services under section 1181(c)(4) of the Social Security Act, and

"(ii) is used primarily for the electronic creation, maintenance, and exchange of medical care information to improve the quality or efficiency of medical care.

"(B) MEDICAL CARE PROVIDER.—The term 'medical care provider' means any person engaged in the trade or business of providing medical care.

"(C) MEDICAL CARE.—The term 'medical care' has the meaning given such term by section 213(d).".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to property placed in service after December 31, 2006.

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