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(Original Signature of Member)

110TH CONGRESS
1ST SESSION

H. R.

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

IN THE HOUSE OF REPRESENTATIVES

Ms. ESHOO introduced the following bill; which was referred to the Committee on _____

A BILL

To advance the adoption of nationwide interoperable health information technology and to improve health care quality and reduce health care costs 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 “Promoting Health In-
5 formation Technology Act”.

6 **SEC. 2. TABLE OF CONTENTS.**

7 The table of contents of this Act is as follows:

Sec. 1. Short title.

Sec. 2. Table of contents.

TITLE I—IMPROVING THE INTEROPERABILITY OF HEALTH
INFORMATION TECHNOLOGY

Sec. 101. Improving health care quality, safety, and efficiency.

“TITLE XXX—HEALTH INFORMATION TECHNOLOGY AND
QUALITY

“Sec. 3001. Definitions; reference.

“Sec. 3002. Office of the national coordinator of health information technology.

“Sec. 3003. Partnership for health care improvement-standards and technology.

“Sec. 3004. American health information community policies.

“Sec. 3005. Federal purchasing and data collection.

“Sec. 3006. Quality and efficiency reports.

“Sec. 3007. Research access to health care data and reporting on performance.

TITLE II—FACILITATING THE WIDESPREAD ADOPTION OF
INTEROPERABLE HEALTH INFORMATION TECHNOLOGY

Sec. 201. Facilitating the widespread adoption of interoperable health information technology.

“Sec. 3008. Facilitating the widespread adoption of interoperable health information technology.

“Sec. 3009. Demonstration program to integrate information technology into clinical education.

TITLE III—IMPROVING THE QUALITY OF HEALTH CARE

Sec. 301. Consensus process for the adoption of quality measures for use in the nationwide interoperable health information technology infrastructure.

“Sec. 3010. Fostering development and use of health care quality measures.

“Sec. 3011. Adoption and use of quality measures; reporting.

TITLE IV—PRIVACY AND SECURITY

Sec. 401. Privacy and security.

“Sec. 3012. Ensuring privacy and security.

TITLE V—MISCELLANEOUS PROVISIONS

Sec. 501. GAO study.

Sec. 502. Health information technology resource center.

Sec. 503. Facilitating the provision of telehealth services across state lines.

“Sec. 330L Telemedicine; incentive grants regarding coordination among States.

1 **TITLE I—IMPROVING THE**
2 **INTEROPERABILITY OF**
3 **HEALTH INFORMATION TECH-**
4 **NOLOGY**

5 **SEC. 101. IMPROVING HEALTH CARE QUALITY, SAFETY,**
6 **AND EFFICIENCY.**

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

9 **“TITLE XXX—HEALTH INFORMA-**
10 **TION TECHNOLOGY AND**
11 **QUALITY**

12 **“SEC. 3001. DEFINITIONS; REFERENCE.**

13 “(a) IN GENERAL.—In this title:

14 “(1) COMMUNITY.—The term ‘Community’
15 means the American Health Information Community
16 established under section 3004.

17 “(2) HEALTH CARE PROVIDER.—The term
18 ‘health care provider’ means a hospital, skilled nurs-
19 ing facility, home health entity, health care clinic,
20 federally qualified health center, group practice (as
21 defined in section 1877(h)(4) of the Social Security
22 Act), a pharmacist, a pharmacy, a laboratory, a phy-
23 sician (as defined in section 1861(r) of the Social
24 Security Act), a practitioner (as defined in section
25 1842(b)(18)(C) of the Social Security Act), a health

1 facility operated by or pursuant to a contract with
2 the Indian Health Service, a rural health clinic, and
3 any other category of facility or clinician determined
4 appropriate by the Secretary.

5 “(3) HEALTH INFORMATION.—The term ‘health
6 information’ has the meaning given such term in
7 section 1171(4) of the Social Security Act.

8 “(4) HEALTH INSURANCE PLAN.—

9 “(A) IN GENERAL.—The term ‘health in-
10 surance plan’ means—

11 “(i) a health insurance issuer (as de-
12 fined in section 2791(b)(2));

13 “(ii) a group health plan (as defined
14 in section 2791(a)(1)); and

15 “(iii) a health maintenance organiza-
16 tion (as defined in section 2791(b)(3)); or

17 “(iv) a safety net health plan.

18 “(B) SAFETY NET HEALTH PLAN.—The
19 term ‘safety net health plan’ means a managed
20 care organization, as defined in section
21 1932(a)(1)(B)(i) of the Social Security Act—

22 “(i) that is exempt from or not sub-
23 ject to Federal income tax, or that is
24 owned by an entity or entities exempt from
25 or not subject to Federal income tax; and

1 “(ii) for which not less than 75 per-
2 cent of the enrolled population receives
3 benefits under a Federal health care pro-
4 gram (as defined in section 1128B(f)(1) of
5 the Social Security Act) or a health care
6 plan or program which is funded, in whole
7 or in part, by a State (other than a pro-
8 gram for government employees).

9 “(C) REFERENCES.—All references in this
10 title to the term ‘health plan’ shall be deemed
11 to be references to a health insurance plan.

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

16 “(6) LABORATORY.—The term ‘laboratory’ has
17 the meaning given such term in section 353.

18 “(7) NATIONAL COORDINATOR.—The term ‘Na-
19 tional Coordinator’ means the National Coordinator
20 of Health Information Technology appointed pursu-
21 ant to section 3002.

22 “(8) PARTNERSHIP.—The term ‘Partnership’
23 means the Partnership for Health Care Improve-
24 ment established under section 3003.

1 “(9) QUALIFIED HEALTH INFORMATION TECH-
2 NOLOGY.—The term ‘qualified health information
3 technology’ means a computerized system (including
4 hardware, software, or provision of service) that—

5 “(A) protects the privacy and security of
6 health information;

7 “(B) maintains and provides permitted ac-
8 cess to health information in an electronic for-
9 mat;

10 “(C) complies with the standards adopted
11 by the Federal Government under section 3003;

12 “(D) has the ability to transmit and ex-
13 change information to other health information
14 technology systems and, to the extent feasible,
15 public health information technology systems;

16 “(E) allows for the electronic capture and
17 reporting of quality measures adopted under
18 section 3011; and

19 “(F) has been certified by the Secretary or
20 a designee of the Secretary to be in compliance
21 with any applicable standards and implementa-
22 tion specifications adopted by the Secretary on
23 or prior to the date of the enactment of this
24 title.

1 “(10) INTEROPERABILITY.—The term ‘inter-
2 operability’ means the ability of different informa-
3 tion technology systems and software applications to
4 communicate, exchange data accurately, effectively,
5 and consistently, and use the information that has
6 been exchanged.

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

11 “(b) REFERENCES TO SOCIAL SECURITY ACT.—Any
12 reference in this section to the Social Security Act shall
13 be deemed to be a reference to such Act as in effect on
14 the date of the enactment of this title.

15 **“SEC. 3002. OFFICE OF THE NATIONAL COORDINATOR OF**
16 **HEALTH INFORMATION TECHNOLOGY.**

17 “(a) ESTABLISHMENT.—There is established within
18 the office of the Secretary the Office of the National Coor-
19 dinator of Health Information Technology, to be headed
20 by the National Coordinator of Health Information Tech-
21 nology. The National Coordinator shall be appointed by
22 the Secretary in consultation with the President, and shall
23 report directly to the Secretary.

24 “(b) PURPOSE.—The National Coordinator shall be
25 responsible for—

1 “(1) ensuring that key health information tech-
2 nology initiatives are coordinated across programs of
3 the Department of Health and Human Services;

4 “(2) ensuring that health information tech-
5 nology policies and programs of the Department of
6 Health and Human Services are coordinated with
7 such policies and programs of other relevant Federal
8 agencies (including Federal commissions and advi-
9 sory committees) with a goal of avoiding duplication
10 of efforts and of helping to ensure that each agency
11 undertakes activities primarily within the areas of its
12 greatest expertise and technical capability;

13 “(3) reviewing Federal health information tech-
14 nology investments to ensure that Federal health in-
15 formation technology programs are meeting the ob-
16 jectives of the strategic plan published by the Office
17 of the National Coordinator of Health Information
18 Technology to establish a nationwide interoperable
19 health information technology infrastructure;

20 “(4) providing comments and advice regarding
21 specific Federal health information technology pro-
22 grams, at the request of Office of Management and
23 Budget; and

24 “(5) enhancing the use of health information
25 technology to improve the quality of health care in

1 the prevention and management of chronic disease
2 and to address population health.

3 “(c) ROLE WITH COMMUNITY AND THE PARTNER-
4 SHIP.—The National Coordinator shall—

5 “(1) serve as an ex officio member of the Com-
6 munity, and act as a liaison between the Federal
7 Government and the Community;

8 “(2) serve as an ex officio member of the Part-
9 nership and act as a liaison between the Federal
10 Government and the Partnership; and

11 “(3) serve as a liaison between the Partnership
12 and the Community.

13 “(d) REPORTS AND WEBSITE.—The National Coordi-
14 nator shall—

15 “(1) develop and publish a strategic plan for
16 implementing a nationwide interoperable health in-
17 formation technology infrastructure;

18 “(2) maintain and frequently update an Inter-
19 net website that—

20 “(A) publishes the schedule for the assess-
21 ment of standards for significant use cases;

22 “(B) publishes the recommendations of the
23 Community;

24 “(C) publishes the recommendations of the
25 Partnership;

1 “(D) publishes quality measures;

2 “(E) identifies sources of funds that will
3 be made available to facilitate the purchase of,
4 or enhance the utilization of, health information
5 technology systems, either through grants or
6 technical assistance; and

7 “(F) publishes a plan for a transition of
8 any functions of the Office of the National Co-
9 ordinator of Health Information Technology
10 that should be continued after September 30,
11 2014;

12 “(3) prepare a report on the lessons learned
13 from major public and private health care systems
14 that have implemented health information tech-
15 nology systems, including an explanation of whether
16 the systems and practices developed by such systems
17 may be applicable to and usable in whole or in part
18 by other health care providers; and

19 “(4) assess the impact of health information
20 technology in communities with health disparities
21 and identify practices to increase the adoption of
22 such technology by health care providers in such
23 communities.

24 “(e) RULE OF CONSTRUCTION.—Nothing in this sec-
25 tion shall be construed as requiring the duplication of Fed-

1 eral efforts with respect to the establishment of the Office
2 of the National Coordinator of Health Information Tech-
3 nology, regardless of whether such efforts are carried out
4 before or after the date of the enactment of this title.

5 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
6 are authorized to be appropriated to carry out this section,
7 such sums as may be necessary for each of fiscal years
8 2008 through 2012.

9 “(g) SUNSET.—The provisions of this section shall
10 not apply after September 30, 2014.

11 **“SEC. 3003. PARTNERSHIP FOR HEALTH CARE IMPROVE-**
12 **MENT-STANDARDS AND TECHNOLOGY.**

13 “(a) ESTABLISHMENT.—

14 “(1) IN GENERAL.—There is established a pub-
15 lic-private Partnership for Health Care Improvement
16 to—

17 “(A) provide advice to the Secretary and
18 the Nation and recommend specific actions to
19 achieve a nationwide interoperable health infor-
20 mation technology infrastructure;

21 “(B) make recommendations concerning
22 standards, implementation specifications, and
23 certification criteria for the electronic exchange
24 of health information (including for the report-
25 ing of quality data under section 3011) for

1 adoption by the Federal Government and vol-
2 untary adoption by private entities;

3 “(C) serve as a forum for the participation
4 of a broad range of stakeholders with specific
5 technical expertise in the development of stand-
6 ards, implementation specifications, and certifi-
7 cation criteria to provide input on the effective
8 implementation of health information tech-
9 nology systems; and

10 “(D) develop and maintain an Internet
11 website that—

12 “(i) publishes established governance
13 rules (including a subsequent appointment
14 process);

15 “(ii) publishes a business plan;

16 “(iii) publishes meeting notices at
17 least 14 days prior to each meeting;

18 “(iv) publishes meeting agendas at
19 least 7 days prior to each meeting; and

20 “(v) publishes meeting materials at
21 least 3 days prior to each meeting.

22 “(2) LIMITATION.—The Partnership shall not
23 meet or take any action until an advisory committee
24 charter has been filed with the Secretary and with
25 the appropriate committees of the Senate and House

1 of Representatives for the Community described in
2 section 3004.

3 “(b) MEMBERSHIP.—

4 “(1) APPOINTMENTS.—

5 “(A) IN GENERAL.—The Partnership shall
6 be composed of members to be appointed as fol-
7 lows:

8 “(i) 2 members shall be appointed by
9 the Secretary.

10 “(ii) 1 member shall be appointed by
11 the majority leader of the Senate.

12 “(iii) 1 member shall be appointed by
13 the minority leader of the Senate.

14 “(iv) 1 member shall be appointed by
15 the Speaker of the House of Representa-
16 tives.

17 “(v) 1 member shall be appointed by
18 the minority leader of the House of Rep-
19 resentatives.

20 “(vi) 7 members shall be appointed by
21 the Comptroller General of the United
22 States of whom—

23 “(I) 1 member shall be a rep-
24 resentative of consumer or patient or-
25 ganizations;

1 “(II) 1 member shall be a rep-
2 representative of organizations with ex-
3 pertise in privacy;

4 “(III) 1 member shall be a rep-
5 representative of organizations with ex-
6 pertise in security;

7 “(IV) 1 member shall be a rep-
8 representative of health care providers;

9 “(V) 1 member shall be a rep-
10 representative of health plans or other
11 third party payers;

12 “(VI) 1 member shall be a rep-
13 representative of information technology
14 vendors; and

15 “(VII) 1 member shall be a rep-
16 representative of purchasers or employ-
17 ers.

18 “(B) NATIONAL COORDINATOR.—The Na-
19 tional Coordinator shall be a member of the
20 Partnership and act as a liaison among the
21 Partnership, the Community, and the Federal
22 Government.

23 “(2) CHAIRPERSON AND VICE CHAIRPERSON.—
24 The Partnership shall designate 1 member to serve

1 as the chairperson and 1 member to serve as the
2 vice chairperson of the Partnership.

3 “(3) BALANCE.—In appointing members under
4 paragraph (1)(A)(vi), the Comptroller General of the
5 United States shall ensure a balance among various
6 sectors of the health care system so that no single
7 sector unduly influences the recommendations of the
8 Partnership.

9 “(4) TERMS.—Members appointed under para-
10 graph (1)(A) shall serve for 3 year terms, except
11 that any member appointed to fill a vacancy for an
12 unexpired term shall be appointed for the remainder
13 of 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 “(5) OUTSIDE INVOLVEMENT.—The Partner-
17 ship shall ensure an adequate opportunity for the
18 participation of outside advisors, including individ-
19 uals with expertise in—

20 “(A) health information privacy;

21 “(B) health information security;

22 “(C) health care quality and patient safety,
23 including individuals with expertise in utilizing
24 health information technology to improve health
25 care quality and patient safety;

1 “(D) medical and clinical research data ex-
2 change; and

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

6 “(6) QUORUM.—Two-thirds of the members of
7 the Partnership shall constitute a quorum for the
8 purpose of conducting votes.

9 “(c) STANDARDS AND IMPLEMENTATION SPECIFICA-
10 TIONS.—

11 “(1) SCHEDULE.—Not later than 90 days after
12 the date of the enactment of this title, the Partner-
13 ship shall develop a schedule for the assessment of
14 standards and implementation specifications under
15 this section. The Partnership shall update such
16 schedule annually. The Secretary shall publish such
17 schedule in the Federal Register and on the Internet
18 website of the Department of Health and Human
19 Services.

20 “(2) FIRST YEAR RECOMMENDATIONS.—Con-
21 sistent with the schedule published under paragraph
22 (1) and not later than 1 year after the date of the
23 enactment of this title, the Partnership shall rec-
24 ommend, and the Secretary shall review, such stand-
25 ards and implementation specifications.

1 “(3) ONGOING RECOMMENDATIONS.—The Part-
2 nership shall review and modify, as appropriate but
3 at least annually, adopted standards and implemen-
4 tation specifications and continue to recommend ad-
5 ditional standards and implementation specifications,
6 consistent with the schedule published pursuant to
7 paragraph (1). The Secretary shall review such
8 modifications and recommendations.

9 “(4) FOCUS OF RECOMMENDATIONS.—The rec-
10 ommendations for standards and implementation
11 specifications under paragraphs (2) and (3) shall
12 focus on health care information technologies that
13 have the greatest potential to improve the quality
14 and efficiency of health care, including—

15 “(A) technologies that protect the privacy
16 of health information and promote security;

17 “(B) interoperable electronic health
18 records;

19 “(C) replacement of paper forms with elec-
20 tronic alternatives;

21 “(D) self-service technologies that facilitate
22 the provision of patient information and reduce
23 wait times;

1 “(E) telemedicine technologies that reduce
2 travel requirements for patients in remote
3 areas;

4 “(F) technologies that facilitate home
5 health care and the monitoring of patients
6 recuperating at home;

7 “(G) technologies that help reduce medical
8 errors;

9 “(H) technologies that facilitate the con-
10 tinuity of care among health settings; and

11 “(I) any other technology that the Partner-
12 ship finds to be among the technologies with
13 the greatest potential to improve the quality
14 and efficiency of health care.

15 “(5) RECOGNITION OF PRIVATE ENTITIES.—

16 The Partnership, in consultation with the Secretary,
17 may recognize a private entity or entities for the
18 purpose of developing and updating standards and
19 implementation specifications to achieve uniform and
20 consistent implementation of the standards adopted
21 by the President under paragraph (9). Such entity
22 or entities shall make recommendations to the Part-
23 nership consistent with this section.

24 “(6) PUBLICATION.—All recommendations
25 made by the Partnership pursuant to this section

1 shall be published in the Federal Register and on
2 the Internet website of the Office of the National
3 Coordinator of Health Information Technology.

4 “(7) PILOT TESTING.—The Secretary may con-
5 duct, or recognize a private entity or entities to con-
6 duct, a pilot project to test the standards and imple-
7 mentation specifications developed under this sub-
8 section before the Partnership issues recommenda-
9 tions on such standards and implementation speci-
10 fications in order to provide for the efficient imple-
11 mentation of such standards and implementation
12 specifications.

13 “(8) PUBLIC INPUT.—The Partnership shall
14 conduct open public meetings and develop a process
15 to allow for public comment on the schedule and rec-
16 ommendations described in this subsection. Such
17 process shall ensure that such comments will be sub-
18 mitted within 30 days after the publication of a rec-
19 ommendation under this subsection.

20 “(9) FEDERAL ACTION.—Not later than 90
21 days after the issuance of a recommendation from
22 the Partnership under this subsection, the Secretary,
23 the Secretary of Veterans Affairs, and the Secretary
24 of Defense, in collaboration with representatives of
25 other relevant Federal agencies as determined ap-

1 appropriate by the President, shall jointly review such
2 recommendation. If appropriate, the President shall
3 provide for the adoption by the Federal Government
4 of any standard or implementation specification con-
5 tained in such recommendation. Such determination
6 shall be published in the Federal Register and on
7 the Internet website of the Office of the National
8 Coordinator of Health Information Technology with-
9 in 30 days after such determination is made.

10 “(10) CONSISTENCY.—The standards and im-
11 plementation specifications described in this sub-
12 section shall be consistent with the standards for in-
13 formation transactions and data elements developed
14 pursuant to the regulations promulgated under sec-
15 tion 264(c) of the Health Insurance Portability and
16 Accountability Act of 1996.

17 “(d) CERTIFICATION.—

18 “(1) DEVELOPING CRITERIA.—The Partner-
19 ship, in consultation with the Secretary, may recog-
20 nize a private entity or entities for the purpose of
21 developing and recommending to the Partnership
22 criteria to certify that appropriate categories of
23 health information technology products that claim to
24 be in compliance with applicable standards and im-

1 plementation specifications adopted under this title
2 have established such compliance.

3 “(2) ADOPTION OF CRITERIA.—The Secretary,
4 based upon the recommendations of the Partnership,
5 shall review and, if appropriate, adopt such criteria.

6 “(3) CONDUCTING CERTIFICATION.—The Sec-
7 retary may recognize a private entity or entities to
8 conduct the certifications described in paragraph (1)
9 using the criteria adopted by the Secretary under
10 this subsection.

11 “(e) RULE OF CONSTRUCTION.—Nothing in this sec-
12 tion shall be construed as disrupting existing activities de-
13 scribed in subsection (c) or (d).

14 “(f) REQUIREMENT TO CONSIDER RECOMMENDA-
15 TIONS.—In carrying out the activities described in sub-
16 sections (c) and (d), the Partnership shall adopt and inte-
17 grate the recommendations of the Community that are
18 adopted by the Secretary.

19 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
20 are authorized to be appropriated to carry out this section,
21 such sums as may be necessary for each of fiscal years
22 2008 through 2012.

1 **“SEC. 3004. AMERICAN HEALTH INFORMATION COMMUNITY**
2 **POLICIES.**

3 “(a) ESTABLISHMENT.—There is established a com-
4 mittee to be known as the American Health Information
5 Community. The Community shall—

6 “(1) provide advice to the Secretary and the
7 heads of any relevant Federal agencies concerning
8 the policy considerations related to health informa-
9 tion technology;

10 “(2) not later than 1 year after the date of the
11 enactment of this title, and annually thereafter,
12 make recommendations concerning a policy frame-
13 work for the development and adoption of a nation-
14 wide interoperable health information technology in-
15 frastructure;

16 “(3) not later than 1 year after the date of the
17 enactment of this title, and annually thereafter,
18 make recommendations concerning national policies
19 for adoption by the Federal Government, and vol-
20 untary adoption by private entities, to support the
21 widespread adoption of health information tech-
22 nology, including—

23 “(A) the protection of individually identifi-
24 able health information, including policies con-
25 cerning the individual’s ability to control the ac-

1 quisition, uses, and disclosures of individually
2 identifiable health information;

3 “(B) methods to protect individually iden-
4 tifiable health information from improper use
5 and disclosures and methods to notify patients
6 if their individually identifiable health informa-
7 tion is wrongfully disclosed;

8 “(C) methods to facilitate secure access to
9 such individual’s individually identifiable health
10 information;

11 “(D) the appropriate uses of a nationwide
12 health information network including—

13 “(i) the collection of quality data and
14 public reporting;

15 “(ii) biosurveillance and public health;

16 “(iii) medical and clinical research;

17 and

18 “(iv) drug safety;

19 “(E) fostering the public understanding of
20 health information technology;

21 “(F) strategies to enhance the use of
22 health information technology in preventing and
23 managing chronic disease;

24 “(G) policies to incorporate the input of
25 employees of health care providers in the design

1 and implementation of health information tech-
2 nology systems; and

3 “(H) other policies determined to be nec-
4 essary by the Community; and

5 “(4) serve as a forum for the participation of
6 a broad range of stakeholders to provide input on
7 improving the effective implementation of health in-
8 formation technology systems.

9 “(b) PUBLICATION.—All recommendations made by
10 the Community pursuant to this section shall be published
11 in the Federal Register and on the Internet website of the
12 National Coordinator. The Secretary shall review all such
13 recommendations, determine which such recommendations
14 should be endorsed by the Federal Government, and pub-
15 lish such determinations on the Internet website of the Of-
16 fice of the National Coordinator of Health Information
17 Technology within 30 days after the date on which each
18 such determination is made.

19 “(c) MEMBERSHIP.—

20 “(1) IN GENERAL.—The Community shall be
21 composed of members to be appointed as follows:

22 “(A) 3 members shall be appointed by the
23 Secretary, 1 of whom shall be appointed to rep-
24 resent the Department of Health and Human
25 Services.

1 “(B) 1 member shall be appointed by the
2 Secretary of Veterans Affairs to represent the
3 Department of Veterans Affairs.

4 “(C) 1 member shall be appointed by the
5 Secretary of Defense to represent the Depart-
6 ment of Defense.

7 “(D) 1 member shall be appointed by the
8 majority leader of the Senate.

9 “(E) 1 member shall be appointed by the
10 minority leader of the Senate.

11 “(F) 1 member shall be appointed by the
12 Speaker of the House of Representatives.

13 “(G) 1 member shall be appointed by the
14 minority leader of the House of Representa-
15 tives.

16 “(H) 9 members shall be appointed by the
17 Comptroller General of the United States of
18 whom—

19 “(i) 1 member shall be an advocate
20 for patients or consumers;

21 “(ii) 1 member shall represent health
22 care providers;

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

1 “(iv) 1 member shall have expertise in
2 privacy and security;

3 “(v) 1 member shall have expertise in
4 improving the health of vulnerable popu-
5 lations;

6 “(vi) 1 member shall represent health
7 plans or other third party payers;

8 “(vii) 1 member shall represent infor-
9 mation technology vendors;

10 “(viii) 1 member shall represent pur-
11 chasers or employers; and

12 “(ix) 1 member shall have expertise in
13 health care quality measurement and re-
14 porting.

15 “(2) CHAIRPERSON AND VICE CHAIRPERSON.—
16 The Community shall designate 1 member to serve
17 as the chairperson and 1 member to serve as the
18 vice chairperson of the Community.

19 “(3) NATIONAL COORDINATOR.—The National
20 Coordinator shall be a member of the Community
21 and act as a liaison among the Community, the
22 partnership, and the Federal Government.

23 “(4) PARTICIPATION.—The members of the
24 Community appointed under paragraph (1) shall
25 represent a balance among various sectors of the

1 health care system so that no single sector unduly
2 influences the recommendations of the Community.

3 “(5) TERMS.—

4 “(A) IN GENERAL.—The terms of mem-
5 bers of the Community shall be 3 years except
6 that the Comptroller General of the United
7 States shall designate staggered terms for the
8 members first appointed under paragraph
9 (1)(H).

10 “(B) VACANCIES.—Any member appointed
11 to fill a vacancy in the membership of the Com-
12 munity that occurs prior to the expiration of
13 the term for which the member’s predecessor
14 was appointed shall be appointed only for the
15 remainder of that term. A member may serve
16 after the expiration of that member’s term until
17 a successor has been appointed. A vacancy in
18 the Community shall be filled in the manner in
19 which the original appointment was made.

20 “(6) OUTSIDE INVOLVEMENT.—The Commu-
21 nity shall ensure an adequate opportunity for the
22 participation of outside advisors, including individ-
23 uals with expertise in—

24 “(A) health information privacy and secu-
25 rity;

1 “(B) improving the health of vulnerable
2 populations;

3 “(C) health care quality and patient safety,
4 including individuals with expertise in measure-
5 ment and the use of health information tech-
6 nology to capture data to improve health care
7 quality and patient safety;

8 “(D) medical ethics;

9 “(E) medical and clinical research data ex-
10 change; and

11 “(F) developing health information tech-
12 nology standards and new health information
13 technology.

14 “(7) QUORUM.—Ten members of the Commu-
15 nity shall constitute a quorum for purposes of vot-
16 ing, but a lesser number of members may meet and
17 hold hearings.

18 “(d) FEDERAL AGENCIES.—

19 “(1) STAFF OF OTHER FEDERAL AGENCIES.—
20 Upon the request of the Community, the head of any
21 Federal agency may detail, without reimbursement,
22 any of the personnel of such agency to the Commu-
23 nity to assist in carrying out the duties of the Com-
24 munity. Any such detail shall not interrupt or other-

1 wise affect the civil service status or privileges of the
2 Federal employee involved.

3 “(2) TECHNICAL ASSISTANCE.—Upon the re-
4 quest of the Community, the head of a Federal
5 agency shall provide such technical assistance to the
6 Community as the Community determines to be nec-
7 essary to carry out its duties.

8 “(3) OTHER RESOURCES.—The Community
9 shall have reasonable access to materials, resources,
10 statistical data, and other information from the Li-
11 brary of Congress and agencies and elected rep-
12 resentatives of the executive and legislative branches
13 of the Federal Government. The chairperson or vice
14 chairperson of the Community shall make requests
15 for such access in writing when necessary.

16 “(e) APPLICATION OF FACA.—The Federal Advisory
17 Committee Act (5 U.S.C. App.) shall apply to the Commu-
18 nity, except that the term provided for under section
19 14(a)(2) of such Act shall be not longer than 7 years.

20 “(f) SUNSET.—The provisions of this section shall
21 not apply after September 20, 2014.

22 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
23 are authorized to be appropriated to carry out this section
24 such sums as may be necessary for each of fiscal years
25 2008 through 2012.

1 **“SEC. 3005. FEDERAL PURCHASING AND DATA COLLEC-**
2 **TION.**

3 “(a) COORDINATION OF FEDERAL SPENDING.—

4 “(1) IN GENERAL.—Not later than 1 year after
5 the adoption by the President of a recommendation
6 under section 3003(c)(9), a Federal agency shall not
7 expend Federal funds for the purchase of any new
8 health information technology or health information
9 technology system for clinical care or for the elec-
10 tronic retrieval, storage, or exchange of health infor-
11 mation if such technology or system is not consistent
12 with applicable standards adopted by the Federal
13 Government under such section.

14 “(2) RULE OF CONSTRUCTION.—Nothing in
15 paragraph (1) shall be construed to restrict the pur-
16 chase of minor (as determined by the Secretary)
17 hardware or software components in order to mod-
18 ify, correct a deficiency in, or extend the life of exist-
19 ing hardware or software.

20 “(b) VOLUNTARY ADOPTION.—

21 “(1) IN GENERAL.—Any standards and imple-
22 mentation specifications adopted by the Federal
23 Government under section 3003(c)(9) shall be vol-
24 untary with respect to private entities.

25 “(2) REQUIREMENT.—Private entities that
26 enter into a contract with the Federal Government

1 shall adopt the standards and implementation speci-
2 fications adopted by the Federal Government under
3 section 3003 for the purpose of activities under such
4 Federal contract.

5 “(3) RULE OF CONSTRUCTION.—Nothing in
6 this section shall be construed to require that a pri-
7 vate entity that enters into a contract with the Fed-
8 eral Government adopt the standards and implemen-
9 tation specifications adopted by the Federal Govern-
10 ment under this section with respect to activities not
11 related to the contract.

12 “(c) 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 section 3003(c)(9), all Federal agencies collecting
16 health data in an electronic format for the purposes of
17 quality reporting, surveillance, epidemiology, adverse event
18 reporting, research, or for other purposes determined ap-
19 propriate by the Secretary, shall comply with the stand-
20 ards and implementation specifications adopted under
21 such section.

22 **“SEC. 3006. QUALITY AND EFFICIENCY REPORTS.**

23 “(a) PURPOSE.—The purpose of this section is to
24 provide for the development of reports based on Federal
25 health care data and private data that is publicly available

1 or is provided by the entity making the request for the
2 report in order to—

3 “(1) improve the quality and efficiency of
4 health care and advance health care research;

5 “(2) enhance the education and awareness of
6 consumers for evaluating health care services; and

7 “(3) provide the public with reports on national,
8 regional, and provider- and supplier-specific per-
9 formance, which may be in a provider- or supplier-
10 identifiable format.

11 “(b) PROCEDURES FOR THE DEVELOPMENT OF RE-
12 PORTS.—

13 “(1) IN GENERAL.—Notwithstanding section
14 552(b)(6) or 552a(b) of title 5, United States Code,
15 not later than 12 months after the date of the enact-
16 ment of this title, the Secretary, in accordance with
17 the purpose described in subsection (a), shall estab-
18 lish and implement procedures under which an enti-
19 ty may submit a request to a Health Quality Organi-
20 zation for the Organization to develop a report based
21 on—

22 “(A) Federal health care data disclosed to
23 the Organization under subsection (c); and

1 “(B) private data that is publicly available
2 or is provided to the Organization by the entity
3 making the request for the report.

4 “(2) DEFINITIONS.—In this section:

5 “(A) FEDERAL HEALTH CARE DATA.—The
6 term ‘Federal health care data’ means—

7 “(i) de-identified patient enrollment
8 data, reimbursement claims, and survey
9 data maintained by the Secretary or enti-
10 ties under programs, contracts, grants, or
11 memoranda of understanding administered
12 by the Secretary; and

13 “(ii) where feasible, other de-identified
14 patient enrollment data, reimbursement
15 claims, and survey data maintained by the
16 Federal Government or entities under con-
17 tract with the Federal Government.

18 “(B) HEALTH QUALITY ORGANIZATION.—
19 The term ‘Health Quality Organization’ means
20 an entity with a contract under subsection (d).

21 “(c) ACCESS TO FEDERAL HEALTH CARE DATA.—

22 “(1) IN GENERAL.—The procedures established
23 under subsection (b)(1) shall provide for the secure
24 disclosure of Federal health care data to each
25 Health Quality Organization.

1 “(2) UPDATE OF INFORMATION.—Not less than
2 every 6 months, the Secretary shall update the infor-
3 mation disclosed under paragraph (1) to Health
4 Quality Organizations.

5 “(d) HEALTH QUALITY ORGANIZATIONS.—

6 “(1) IN GENERAL.—

7 “(A) THREE CONTRACTS.—Subject to sub-
8 paragraph (B), the Secretary shall enter into a
9 contract with 3 private entities to serve as
10 Health Quality Organizations under which an
11 entity shall—

12 “(i) store the Federal health care data
13 that is to be disclosed under subsection (c);
14 and

15 “(ii) develop and release reports pur-
16 suant to subsection (e).

17 “(B) ADDITIONAL CONTRACTS.—If the
18 Secretary determines that reports are not being
19 developed and released within 6 months of the
20 receipt of the request for the report, the Sec-
21 retary shall enter into contracts with additional
22 private entities in order to ensure that such re-
23 ports are developed and released in a timely
24 manner.

1 “(2) QUALIFICATIONS.—The Secretary shall
2 enter into a contract with an entity under paragraph
3 (1) only if the Secretary determines that the enti-
4 ty—

5 “(A) has the research capability to conduct
6 and complete reports under this section;

7 “(B) has in place—

8 “(i) an information technology infra-
9 structure to support the database of Fed-
10 eral health care data that is to be disclosed
11 to the entity; and

12 “(ii) operational standards to provide
13 security for such database;

14 “(C) has experience with, and expertise on,
15 the development of reports on health care qual-
16 ity and efficiency; and

17 “(D) has a significant business presence in
18 the United States.

19 “(3) CONTRACT REQUIREMENTS.—Each con-
20 tract with an entity under paragraph (1) shall con-
21 tain the following requirements:

22 “(A) ENSURING BENEFICIARY PRIVACY.—

23 “(i) HIPAA.—The entity shall meet
24 the requirements imposed on a covered en-
25 tity for purposes of applying part C of title

1 XI of the Social Security Act and all regu-
2 latory provisions promulgated thereunder,
3 including regulations (relating to privacy)
4 adopted pursuant to the authority of the
5 Secretary under section 264(e) of the
6 Health Insurance Portability and Account-
7 ability Act of 1996.

8 “(ii) PRIVACY.—The entity shall pro-
9 vide assurances that the entity will not use
10 the Federal health care data disclosed
11 under subsection (c) in a manner that vio-
12 lates sections 552 or 552a of title 5,
13 United States Code, with regard to the pri-
14 vacy of individually identifiable health in-
15 formation.

16 “(B) PROPRIETARY INFORMATION.—The
17 entity shall provide assurances that the entity
18 will not disclose any negotiated price conces-
19 sions, such as discounts, direct or indirect sub-
20 sidies, rebates, and direct or indirect remunera-
21 tions, obtained by health care providers or sup-
22 pliers or health care plans, or any other propri-
23 etary cost information.

24 “(C) DISCLOSURE.—The entity shall dis-
25 close—

1 “(i) any financial, reporting, or con-
2 tractual relationship between the entity
3 and any health care provider or supplier or
4 health care plan; and

5 “(ii) if applicable, the fact that the
6 entity is managed, controlled, or operated
7 by any health care provider or supplier or
8 health care plan.

9 “(D) COMPONENT OF ANOTHER ORGANIZA-
10 TION.—If the entity is a component of another
11 organization—

12 “(i) the entity shall maintain Federal
13 health care data and reports separately
14 from the rest of the organization and es-
15 tablish appropriate security measures to
16 maintain the confidentiality and privacy of
17 the Federal health care data and reports;
18 and

19 “(ii) the entity shall not make an un-
20 authorized disclosure to the rest of the or-
21 ganization of Federal health care data or
22 reports in breach of such confidentiality
23 and privacy requirement.

24 “(E) TERMINATION OR NONRENEWAL.—If
25 a contract under this section is terminated or

1 not renewed, the following requirements shall
2 apply:

3 “(i) CONFIDENTIALITY AND PRIVACY
4 PROTECTIONS.—The entity shall continue
5 to comply with the confidentiality and pri-
6 vacy requirements under this section with
7 respect to all Federal health care data dis-
8 closed to the entity and each report devel-
9 oped by the entity.

10 “(ii) DISPOSITION OF DATA AND RE-
11 PORTS.—The entity shall—

12 “(I) return to the Secretary all
13 Federal health care data disclosed to
14 the entity and each report developed
15 by the entity; or

16 “(II) if returning the Federal
17 health care data and reports is not
18 practicable, destroy the reports and
19 Federal health care data.

20 “(4) COMPETITIVE PROCEDURES.—Competitive
21 procedures (as defined in section 4(5) of the Federal
22 Procurement Policy Act) shall be used to enter into
23 contracts under paragraph (1).

24 “(5) REVIEW OF CONTRACT IN THE EVENT OF
25 A MERGER OR ACQUISITION.—The Secretary shall

1 review the contract with a Health Quality Organiza-
2 tion under this section in the event of a merger or
3 acquisition of the Organization in order to ensure
4 that the requirements under this section will con-
5 tinue to be met.

6 “(e) DEVELOPMENT AND RELEASE OF REPORTS
7 BASED ON REQUESTS.—

8 “(1) REQUEST FOR A REPORT.—

9 “(A) REQUEST.—

10 “(i) IN GENERAL.—The procedures
11 established under subsection (b)(1) shall
12 include a process for an entity to submit a
13 request to a Health Quality Organization
14 for a report based on Federal health care
15 data and private data that is publicly avail-
16 able or is provided by the entity making
17 the request for the report. Such request
18 shall comply with the purpose described in
19 subsection (a).

20 “(ii) REQUEST FOR SPECIFIC METH-
21 ODOLOGY.—The process described in
22 clause (i) shall permit an entity making a
23 request for a report to request that a spe-
24 cific methodology, including appropriate
25 risk adjustment, be used by the Health

1 Quality Organization in developing the re-
2 port. The Organization shall work with the
3 entity making the request to finalize the
4 methodology to be used.

5 “(iii) REQUEST FOR A SPECIFIC
6 HEALTH QUALITY ORGANIZATION.—The
7 process described in clause (i) shall permit
8 an entity to submit the request for a re-
9 port to any Health Quality Organization.

10 “(B) RELEASE TO PUBLIC.—The proce-
11 dures established under subsection (b)(1) shall
12 provide that at the time a request for a report
13 is finalized under subparagraph (A) by a
14 Health Quality Organization, the Organization
15 shall make available to the public, through the
16 Internet website of the Department of Health
17 and Human Services and other appropriate
18 means, a brief description of both the requested
19 report and the methodology to be used to de-
20 velop such report.

21 “(2) DEVELOPMENT AND RELEASE OF RE-
22 PORT.—

23 “(A) DEVELOPMENT.—

24 “(i) IN GENERAL.—If the request for
25 a report complies with the purpose de-

1 scribed in subsection (a), the Health Qual-
2 ity Organization may develop the report
3 based on the request.

4 “(ii) REQUIREMENT.—A report devel-
5 oped under clause (i) shall include a de-
6 tailed description of the standards, meth-
7 odologies, and measures of quality used in
8 developing the report.

9 “(B) REVIEW OF REPORT BY SECRETARY
10 TO ENSURE COMPLIANCE WITH PRIVACY RE-
11 QUIREMENT.—Prior to a Health Quality Orga-
12 nization releasing a report under subparagraph
13 (C), the Secretary shall review the report to en-
14 sure that the report complies with the Federal
15 regulations (concerning the privacy of individ-
16 ually identifiable beneficiary health information)
17 promulgated under section 264(e) of the Health
18 Insurance Portability and Accountability Act of
19 1996 and sections 552 or 552a of title 5,
20 United States Code, with regard to the privacy
21 of individually identifiable beneficiary health in-
22 formation. The Secretary shall act within 30
23 business days of receiving such report.

24 “(C) RELEASE OF REPORT.—

1 “(i) RELEASE TO ENTITY MAKING RE-
2 QUEST.—If the Secretary finds that the re-
3 port complies with the provisions described
4 in subparagraph (B), the Health Quality
5 Organization shall release the report to the
6 entity that made the request for the re-
7 port.

8 “(ii) RELEASE TO PUBLIC.—The pro-
9 cedures established under subsection (b)(1)
10 shall provide for the following:

11 “(I) UPDATED DESCRIPTION.—
12 At the time of the release of a report
13 by a Health Quality Organization
14 under clause (i), the entity shall make
15 available to the public, through the
16 Internet website of the Department of
17 Health and Human Services and
18 other appropriate means, an updated
19 brief description of both the requested
20 report and the methodology used to
21 develop such report.

22 “(II) COMPLETE REPORT.—Not
23 later than 1 year after the date of the
24 release of a report under clause (i),
25 the report shall be made available to

1 the public through the Internet
2 website of the Department of Health
3 and Human Services and other appro-
4 priate means.

5 “(f) ANNUAL REVIEW OF REPORTS AND TERMI-
6 NATION OF CONTRACTS.—

7 “(1) ANNUAL REVIEW OF REPORTS.—The
8 Comptroller General of the United States shall re-
9 view reports released under subsection (e)(2)(C) to
10 ensure that such reports comply with the purpose
11 described in subsection (a) and annually submit a
12 report to the Secretary on such review.

13 “(2) TERMINATION OF CONTRACTS.—The Sec-
14 retary may terminate a contract with a Health Qual-
15 ity Organization if the Secretary determines that
16 there is a pattern of reports being released by the
17 Organization that do not comply with the purpose
18 described in subsection (a).

19 “(g) FEES.—

20 “(1) FEES FOR SECRETARY.—The Secretary
21 shall charge a Health Quality Organization a fee
22 for—

23 “(A) disclosing the data under subsection
24 (c); and

1 “(B) conducting the review under sub-
2 section (e)(2)(B).

3 The Secretary shall ensure that such fees are suffi-
4 cient to cover the costs of the activities described in
5 subparagraphs (A) and (B).

6 “(2) FEES FOR HQO.—

7 “(A) IN GENERAL.—Subject to subpara-
8 graphs (B) and (C), a Health Quality Organiza-
9 tion may charge an entity making a request for
10 a report a reasonable fee for the development
11 and release of the report.

12 “(B) DISCOUNT FOR SMALL ENTITIES.—In
13 the case of an entity making a request for a re-
14 port (including a not-for-profit entity) that has
15 annual revenue that does not exceed
16 \$10,000,000, the Health Quality Organization
17 shall reduce the reasonable fee charged to such
18 entity under subparagraph (A) by an amount
19 equal to 10 percent of such fee.

20 “(C) INCREASE FOR LARGE ENTITIES
21 THAT DO NOT AGREE TO RELEASE REPORTS
22 WITHIN 6 MONTHS.—In the case of an entity
23 making a request for a report that is not de-
24 scribed in subparagraph (B) and that does not
25 agree to the report being released to the public

1 under clause (ii)(II) of subsection (e)(2)(C)
2 within 6 months of the date of the release of
3 the report to the entity under clause (i) of such
4 subsection, the Health Quality Organization
5 shall increase the reasonable fee charged to
6 such entity under subparagraph (A) by an
7 amount equal to 10 percent of such fee.

8 “(D) RULE OF CONSTRUCTION.—Nothing
9 in this paragraph shall be construed to effect
10 the requirement that a report be released to the
11 public under clause (ii)(II) of subsection
12 (e)(2)(C) by not later than 1 year after the date
13 of the release of the report to the requesting en-
14 tity under clause (i) of such subsection.

15 “(h) COORDINATION.—Not later than 1 year after
16 the date of the enactment of this title, the Secretary shall
17 submit a report (including recommendations) to the ap-
18 propriate committees of Congress concerning the coordina-
19 tion of existing Federal health care quality initiatives.

20 “(i) REGULATIONS.—Not later than 6 months after
21 the date of the enactment of this title, the Secretary shall
22 prescribe regulations to carry out this section.

1 **“SEC. 3007. RESEARCH ACCESS TO HEALTH CARE DATA**
2 **AND REPORTING ON PERFORMANCE.**

3 “The Secretary shall permit researchers that meet
4 criteria used to evaluate the appropriateness of the release
5 data for research purposes (as established by the Sec-
6 retary) to—

7 “(1) have access to all Federal health care data
8 (as defined in section 3006(b)(2)(A)); and

9 “(2) report on the performance of health care
10 providers and suppliers, including reporting in a
11 provider- or supplier-identifiable format.”.

12 **TITLE II—FACILITATING THE**
13 **WIDESPREAD ADOPTION OF**
14 **INTEROPERABLE HEALTH IN-**
15 **FORMATION TECHNOLOGY**

16 **SEC. 201. FACILITATING THE WIDESPREAD ADOPTION OF**
17 **INTEROPERABLE HEALTH INFORMATION**
18 **TECHNOLOGY.**

19 Title XXX of the Public Health Service Act, as added
20 by section 101, is amended by adding at the end the fol-
21 lowing:

22 **“SEC. 3008. FACILITATING THE WIDESPREAD ADOPTION OF**
23 **INTEROPERABLE HEALTH INFORMATION**
24 **TECHNOLOGY.**

25 “(a) **COMPETITIVE GRANTS FOR ADOPTION OF**
26 **TECHNOLOGY.—**

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

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

8 “(A) submit to the Secretary an applica-
9 tion at such time, in such manner, and con-
10 taining such information as the Secretary may
11 require;

12 “(B) submit to the Secretary a strategic
13 plan for the implementation of data sharing
14 and interoperability measures;

15 “(C) adopt the standards adopted by the
16 Federal Government under section 3003;

17 “(D) implement the measures adopted
18 under section 3011 and report to the Secretary
19 on such measures;

20 “(E) agree to notify individuals if their in-
21 dividually identifiable health information is
22 wrongfully disclosed;

23 “(F) take into account the input of em-
24 ployees and staff who are directly involved in
25 patient care of such health care providers in the

1 design, implementation, and use of qualified
2 health information technology systems;

3 “(G) demonstrate significant financial
4 need;

5 “(H) provide matching funds in accord-
6 ance with paragraph (4); and

7 “(I) be a—

8 “(i) public or not-for-profit hospital;

9 “(ii) federally qualified health center
10 (as defined in section 1861(aa)(4) of the
11 Social Security Act);

12 “(iii) individual or group practice (or
13 a consortium thereof); or

14 “(iv) another health care provider not
15 described in clause (i) or (ii);

16 that serves medically underserved communities.

17 “(3) USE OF FUNDS.—Amounts received under
18 a grant under this subsection shall be used to—

19 “(A) facilitate the purchase of qualified
20 health information technology systems;

21 “(B) train personnel in the use of such
22 systems;

23 “(C) enhance the utilization of qualified
24 health information technology systems (which
25 may include activities to increase the awareness

1 among consumers of health care privacy protec-
2 tions); or

3 “(D) improve the prevention and manage-
4 ment of chronic disease.

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

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

14 “(A) eligible entities that will improve the
15 degree to which such entity will link the quali-
16 fied health information system to local or re-
17 gional health information plan or plans; and

18 “(B) with respect to awards made for the
19 purpose of providing care in an outpatient med-
20 ical setting, entities that organize their prac-
21 tices as a patient-centered medical home.

22 “(b) COMPETITIVE GRANTS FOR THE DEVELOPMENT
23 OF STATE LOAN PROGRAMS TO FACILITATE THE WIDE-
24 SPREAD ADOPTION OF HEALTH INFORMATION TECH-
25 NOLOGY.—

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

6 “(2) ESTABLISHMENT OF FUND.—To be eligi-
7 ble to receive a competitive grant under this sub-
8 section, a State shall establish a qualified health in-
9 formation technology loan fund (referred to in this
10 subsection as a ‘State loan fund’) and comply with
11 the other requirements contained in this subsection.
12 Amounts received under a grant under this sub-
13 section shall be deposited in the State loan fund es-
14 tablished by the State. No funds authorized by other
15 provisions of this title to be used for other purposes
16 specified in this title shall be deposited in any such
17 State loan fund.

18 “(3) ELIGIBILITY.—To be eligible to receive a
19 grant under paragraph (1), a State shall—

20 “(A) submit to the Secretary an applica-
21 tion at such time, in such manner, and con-
22 taining such information as the Secretary may
23 require;

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

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

4 “(D) require that health care providers re-
5 ceiving loans under the grant—

6 “(i) link, to the extent practicable, the
7 qualified health information system to a
8 local or regional health information net-
9 work;

10 “(ii) consult, as needed, with the
11 Health Information Technology Resource
12 Center established in section 914(d) to ac-
13 cess the knowledge and experience of exist-
14 ing initiatives regarding the successful im-
15 plementation and effective use of health in-
16 formation technology;

17 “(iii) agree to notify individuals if
18 their individually identifiable health infor-
19 mation is wrongfully disclosed; and

20 “(iv) take into account the input of
21 employees and staff who are directly in-
22 volved in patient care of such health care
23 providers in the design and implementation
24 and use of qualified health information
25 technology systems;

1 “(E) require that health care providers re-
2 ceiving loans under the grant adopt the stand-
3 ards adopted by the Federal Government under
4 section 3003;

5 “(F) require that health care providers re-
6 ceiving loans under the grant implement the
7 measures adopted under section 3011 and re-
8 port to the Secretary on such measures; and

9 “(G) provide matching funds in accordance
10 with paragraph (8).

11 “(4) STRATEGIC PLAN.—

12 “(A) IN GENERAL.—A State that receives
13 a grant under this subsection shall annually
14 prepare a strategic plan that identifies the in-
15 tended uses of amounts available to the State
16 loan fund of the State.

17 “(B) CONTENTS.—A strategic plan under
18 subparagraph (A) shall include—

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

23 “(ii) a description of the criteria and
24 methods established for the distribution of
25 funds from the State loan fund;

1 “(iii) a description of the financial
2 status of the State loan fund and the
3 short-term and long-term goals of the
4 State loan fund; and

5 “(iv) a description of the strategies
6 the State will use to address challenges in
7 the adoption of health information tech-
8 nology due to limited broadband access.

9 “(5) USE OF FUNDS.—

10 “(A) IN GENERAL.—Amounts deposited in
11 a State loan fund, including loan repayments
12 and interest earned on such amounts, shall be
13 used only for awarding loans or loan guaran-
14 tees, or as a source of reserve and security for
15 leveraged loans, the proceeds of which are de-
16 posited in the State loan fund established under
17 paragraph (1). Loans under this section may be
18 used by a health care provider to—

19 “(i) facilitate the purchase of qualified
20 health information technology systems;

21 “(ii) enhance the utilization of quali-
22 fied health information technology systems
23 (which may include activities to increase
24 the awareness among consumers of health

1 care of privacy protections and privacy
2 rights); or

3 “(iii) train personnel in the use of
4 such systems.

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

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

11 “(ii) to conduct activities for which
12 Federal funds are expended under other
13 provisions of this title or the amendments
14 made by the Promoting Health Informa-
15 tion Technology Act; or

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

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

23 “(A) To award loans that comply with the
24 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 date on which
7 the loan was awarded, and each loan shall
8 be fully amortized not later than 10 years
9 after such date.

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 not otherwise 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 the 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 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, implementation specifications and
15 certification criteria, and other requirements adopted
16 by the Secretary under section 3011.

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) health care providers (including
8 health care providers that provide services
9 to low income and underserved popu-
10 lations);

11 “(ii) pharmacists or pharmacies;

12 “(iii) health plans;

13 “(iv) health centers (as defined in sec-
14 tion 330(b)) and federally qualified health
15 centers (as defined in section 1861(aa)(4)
16 of the Social Security Act) and rural
17 health clinics (as defined in section
18 1861(aa) of the Social Security Act), if
19 such centers or clinics are present in the
20 community served by the entity;

21 “(v) patient or consumer organiza-
22 tions;

23 “(vi) organizations dedicated to im-
24 proving the health of vulnerable popu-
25 lations;

1 “(vii) employers;

2 “(viii) State or local health depart-
3 ments; and

4 “(ix) any other health care providers
5 or other entities, as determined appro-
6 priate by the Secretary;

7 “(D) demonstrate the participation, to the
8 extent practicable, of stakeholders in the elec-
9 tronic exchange of health information within
10 the local or regional plan pursuant to subpara-
11 graph (C);

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

17 “(F) adopt the standards adopted by the
18 Secretary under section 3003;

19 “(G) require that health care providers re-
20 ceiving such grants—

21 “(i) implement the measures adopted
22 under section 3011 and report to the Sec-
23 retary on such measures; and

24 “(ii) take into account the input of
25 employees and staff who are directly in-

1 volved in patient care of such health care
2 providers in the design, implementation,
3 and use of health information technology
4 systems;

5 “(H) agree to notify individuals if their in-
6 dividually identifiable health information is
7 wrongfully disclosed;

8 “(I) facilitate the electronic exchange of
9 health information within the local or regional
10 area and among local and regional areas;

11 “(J) prepare and submit to the Secretary
12 an application in accordance with paragraph
13 (3);

14 “(K) agree to provide matching funds in
15 accordance with paragraph (5); and

16 “(L) reduce barriers to the implementation
17 of health information technology by providers..

18 “(3) APPLICATION.—

19 “(A) IN GENERAL.—To be eligible to re-
20 ceive a grant under paragraph (1), an entity
21 shall submit to the Secretary an application at
22 such time, in such manner, and containing such
23 information as the Secretary may require.

1 “(B) REQUIRED INFORMATION.—At a
2 minimum, an application submitted under this
3 paragraph shall include—

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

7 “(ii) a technology plan that complies
8 with the standards, implementation speci-
9 fications, and certification criteria adopted
10 under section 3003(c)(7) and that includes
11 a descriptive and reasoned estimate of the
12 costs of the hardware, software, training,
13 and consulting services necessary to imple-
14 ment the regional or local health informa-
15 tion plan;

16 “(iii) a strategy that includes initia-
17 tives to improve health care quality and ef-
18 ficiency, including the use and reporting of
19 health care quality measures adopted
20 under section 3011;

21 “(iv) a plan that describes provisions
22 to encourage the implementation of the
23 electronic exchange of health information
24 by all health care providers participating in
25 the health information plan;

1 “(v) a plan to ensure the privacy and
2 security of individually identifiable health
3 information that is consistent with Federal
4 and State law;

5 “(vi) a governance plan that defines
6 the manner in which the stakeholders will
7 jointly make policy and operational deci-
8 sions on an ongoing basis;

9 “(vii) a financial or business plan that
10 describes—

11 “(I) the sustainability of the
12 plan;

13 “(II) the financial costs and ben-
14 efits of the plan; and

15 “(III) the entities to which such
16 costs and benefits will accrue;

17 “(viii) a description of whether the
18 State in which the entity resides has re-
19 ceived a grant under section 319D, alone
20 or as a part of a consortium, and if the
21 State has received such a grant, how the
22 entity will coordinate the activities funded
23 under section 319D with the system under
24 this section; and

1 “(ix) in the case of an applicant entity
2 that is unable to demonstrate the partici-
3 pation of all stakeholders pursuant to
4 paragraph (2)(C), the justification from
5 the entity for any such nonparticipation.

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

10 “(5) MATCHING REQUIREMENT.—

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

23 “(B) DETERMINATION OF AMOUNT CON-
24 TRIBUTED.—Non-Federal contributions re-
25 quired under subparagraph (A) may be in cash

1 or in kind, fairly evaluated, including equip-
2 ment, technology, or services. Amounts provided
3 by the Federal Government, or services assisted
4 or subsidized to any significant extent by the
5 Federal Government, may not be included in
6 determining the amount of such non-Federal
7 contributions.

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

14 “(1) a description of the financial costs and
15 benefits of the project involved and of the entities to
16 which such costs and benefits accrue;

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

19 “(3) a description of any reduction in duplica-
20 tive or unnecessary care as a result of the project in-
21 volved; and

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

24 “(e) AUTHORIZATION OF APPROPRIATIONS.—

1 “(1) IN GENERAL.—For the purpose of car-
2 rying out this section, there are authorized to be ap-
3 propriated \$163,000,000 for fiscal year 2008,
4 \$163,000,000 for fiscal year 2009, and such sums
5 as may be necessary for each of fiscal years 2010
6 through 2012.

7 “(2) AVAILABILITY.—Amounts appropriated
8 pursuant to paragraph (1) shall remain available
9 through fiscal year 2012.

10 **“SEC. 3009. DEMONSTRATION PROGRAM TO INTEGRATE IN-**
11 **FORMATION TECHNOLOGY INTO CLINICAL**
12 **EDUCATION.**

13 “(a) IN GENERAL.—The Secretary may award grants
14 to eligible entities or consortia under this section to carry
15 out demonstration projects to develop academic curricula
16 integrating qualified health information technology sys-
17 tems in the clinical education of health professionals or
18 analyze clinical data sets to discover quality measures.
19 Such awards shall be made on a competitive basis and
20 pursuant to peer review.

21 “(b) ELIGIBILITY.—To be eligible to receive a grant
22 under subsection (a), an entity or consortium shall—

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

1 “(2) be or include—

2 “(A) a health professions school;

3 “(B) a school of nursing; or

4 “(C) an institution with a graduate med-
5 ical education program;

6 “(3) provide for the collection of data regarding
7 the effectiveness of the demonstration project to be
8 funded under the grant in improving the safety of
9 patients and the efficiency of health care delivery;
10 and

11 “(4) provide matching funds in accordance with
12 subsection (d).

13 “(c) USE OF FUNDS.—

14 “(1) IN GENERAL.—With respect to a grant
15 under subsection (a), an eligible entity or consortium
16 shall use amounts received under the grant in col-
17 laboration with 2 or more disciplines.

18 “(2) LIMITATION.—An eligible entity or consor-
19 tium shall not award a grant under subsection (a)
20 to purchase hardware, software, or services.

21 “(d) MATCHING FUNDS.—

22 “(1) IN GENERAL.—The Secretary may award
23 a grant to an entity or consortium under this section
24 only if the entity of consortium agrees to make avail-
25 able non-Federal contributions toward the costs of

1 the program to be funded under the grant in an
2 amount that is not less than \$1 for each \$2 of Fed-
3 eral funds provided under the grant.

4 “(2) DETERMINATION OF AMOUNT CONTRIB-
5 UTED.—Non-Federal contributions under paragraph
6 (1) may be in cash or in kind, fairly evaluated, in-
7 cluding equipment or services. Amounts provided by
8 the Federal Government, or services assisted or sub-
9 sidized to any significant extent by the Federal Gov-
10 ernment, may not be included in determining the
11 amount of such contributions.

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

17 “(f) REPORTS.—Not later than 1 year after the date
18 of the enactment of this title, and annually thereafter, the
19 Secretary shall submit to the Committee on Health, Edu-
20 cation, Labor, and Pensions and the Committee on Fi-
21 nance of the Senate, and the Committee on Energy and
22 Commerce and the Committee on Ways and Means of the
23 House of Representatives a report that—

24 “(1) describes the specific projects established
25 under this section; and

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

4 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
5 are authorized to be appropriated to carry out this section
6 such sums as may be necessary for each of fiscal years
7 2008 through 2011.

8 “(h) SUNSET.—The provisions of this section shall
9 not apply after September 30, 2012.”.

10 **TITLE III—IMPROVING THE**
11 **QUALITY OF HEALTH CARE**

12 **SEC. 301. CONSENSUS PROCESS FOR THE ADOPTION OF**
13 **QUALITY MEASURES FOR USE IN THE NA-**
14 **TIONWIDE INTEROPERABLE HEALTH INFOR-**
15 **MATION TECHNOLOGY INFRASTRUCTURE.**

16 Title XXX of the Public Health Service Act, as
17 amended by section 201, is further amended by adding
18 at the end the following:

19 **“SEC. 3010. FOSTERING DEVELOPMENT AND USE OF**
20 **HEALTH CARE QUALITY MEASURES.**

21 “(a) IN GENERAL.—The Secretary shall provide for
22 the development and use of health care quality measures
23 (referred to in this title as ‘quality measures’) for the pur-
24 pose of measuring the quality and efficiency of health care
25 that patients receive.

1 “(b) DESIGNATION OF, AND ARRANGEMENT WITH,
2 ORGANIZATION.—

3 “(1) IN GENERAL.—Not later than 90 days
4 after the date of the enactment of this title, the Sec-
5 retary shall designate, and have in effect an ar-
6 rangement with, a single organization that meets the
7 requirements of subsection (c) under which such or-
8 ganization will promote the development of quality
9 measures and provide the Secretary with advice and
10 recommendations on the key elements and priorities
11 of a national system for health care performance
12 measurement.

13 “(2) RESPONSIBILITIES.—The responsibilities
14 to be performed by the organization designated
15 under paragraph (1) (referred to in this title as the
16 ‘designated organization’) shall include—

17 “(A) establishing and managing an inte-
18 grated national strategy and process for setting
19 priorities and goals in establishing quality
20 measures;

21 “(B) coordinating and harmonizing the de-
22 velopment and testing of such measures;

23 “(C) establishing standards for the devel-
24 opment and testing of such measures;

1 “(D) endorsing national consensus quality
2 measures;

3 “(E) recommending, in collaboration with
4 multi-stakeholder groups, quality measures to
5 the Secretary for adoption and use;

6 “(F) promoting the development and use
7 of electronic health records that contain the
8 functionality for automated collection, aggrega-
9 tion, and transmission of performance measure-
10 ment information; and

11 “(G) providing recommendations and ad-
12 vice to the Partnership regarding the integra-
13 tion of quality measures into the certification
14 process outlined under section 3003 and the
15 Community regarding national policies outlined
16 under section 3004.

17 “(c) REQUIREMENTS DESCRIBED.—The require-
18 ments described in this subsection are the following:

19 “(1) PRIVATE ENTITY.—The organization shall
20 be a private nonprofit entity that is governed by a
21 board of directors and an individual who is des-
22 ignated as president and chief executive officer.

23 “(2) BOARD MEMBERSHIP.—The members of
24 the board of directors of the entity shall include rep-
25 resentatives of—

1 “(A) health care providers or groups rep-
2 resenting providers;

3 “(B) health plans or groups representing
4 health plans;

5 “(C) patients or consumers enrolled in
6 such plans or groups representing individuals
7 enrolled in such plans;

8 “(D) health care purchasers and employers
9 or groups representing purchasers or employers;
10 and

11 “(E) organizations that develop health in-
12 formation technology standards and new health
13 information technology.

14 “(3) OTHER MEMBERSHIP REQUIREMENTS.—
15 The membership of the board of directors of the en-
16 tity shall be representative of individuals with expe-
17 rience with—

18 “(A) urban health care issues;

19 “(B) safety net health care issues;

20 “(C) rural or frontier health care issues;

21 “(D) quality and safety issues;

22 “(E) State or local health programs;

23 “(F) individuals or entities skilled in the
24 conduct and interpretation of biomedical, health
25 services, and health economics research and

1 with expertise in outcomes and effectiveness re-
2 search and technology assessment; and

3 “(G) individuals or entities involved in the
4 development and establishment of standards
5 and certification for health information tech-
6 nology systems and clinical data.

7 “(4) OPEN AND TRANSPARENT.—With respect
8 to matters related to the arrangement with the Sec-
9 retary under subsection (a)(1), the organization
10 shall conduct its business in an open and trans-
11 parent manner, and provide the opportunity for pub-
12 lic comment and ensure a balance among disparate
13 stakeholders, so that no member organization unduly
14 influences the work of the organization.

15 “(5) VOLUNTARY CONSENSUS STANDARDS SET-
16 TING ORGANIZATIONS.—The organization shall oper-
17 ate as a voluntary consensus standards setting orga-
18 nization as defined for purposes of section 12(d) of
19 the National Technology Transfer and Advancement
20 Act of 1995 (Public Law 104–113) and Office of
21 Management and Budget Revised Circular A–119
22 (published in the Federal Register on February 10,
23 1998).

24 “(6) PARTICIPATION.—If the organization re-
25 quires a fee for membership, the organization shall

1 ensure that such fee is not a substantial barrier to
2 participation in the entity's activities related to the
3 arrangement with the Secretary.

4 “(d) REQUIREMENTS FOR MEASURES.—The quality
5 measures developed under this title shall comply with the
6 following:

7 “(1) MEASURES.—The designated organization,
8 in promoting the development of quality measures
9 under this title, shall ensure that such measures—

10 “(A) are evidence-based, reliable, and
11 valid;

12 “(B) include—

13 “(i) measures of clinical processes and
14 outcomes, patient experience, efficiency,
15 and equity; and

16 “(ii) measures to assess effectiveness,
17 timeliness, patient self-management, pa-
18 tient centeredness, and safety; and

19 “(C) include measures of underuse and
20 overuse.

21 “(2) PRIORITIES.—In carrying out its respon-
22 sibilities under this section, the designated organiza-
23 tion shall ensure that priority is given to—

1 “(A) measures with the greatest potential
2 impact for improving the performance and effi-
3 ciency of care;

4 “(B) measures that may be rapidly imple-
5 mented by group health plans, health insurance
6 issuers, physicians, hospitals, nursing homes,
7 long-term care providers, and other providers;

8 “(C) measures which may inform health
9 care decisions made by consumers and patients;

10 “(D) measures that apply to multiple serv-
11 ices furnished by different providers during an
12 episode of care;

13 “(E) measures that can be integrated into
14 the certification process described in section
15 3003; and

16 “(F) measures that may be integrated into
17 the decision support function of qualified health
18 information technology.

19 “(3) RISK ADJUSTMENT.—The designated orga-
20 nization, in consultation with performance measure
21 developers and other stakeholders, shall establish
22 procedures to ensure that quality measures take into
23 account differences in patient health status, patient
24 characteristics, and geographic location, as appro-
25 priate.

1 “(4) MAINTENANCE.—The designated organiza-
2 tion, in consultation with owners and developers of
3 quality measures, shall require the owners or devel-
4 opers of quality measures to update and enhance
5 such measures, including the development of more
6 accurate and precise specifications, and retire exist-
7 ing outdated measures. Such updating shall occur
8 not more often than once during each 12-month pe-
9 riod, except in the case of emergency circumstances
10 requiring a more immediate update to a measure.

11 “(e) GRANTS FOR PERFORMANCE MEASURE DEVEL-
12 OPMENT.—The Secretary, acting through the Agency for
13 Healthcare Research and Quality, may award grants, in
14 amounts not to exceed \$50,000 each, to organizations to
15 support the development and testing of quality measures
16 that meet the standards established by the designated or-
17 ganization.

18 **“SEC. 3011. ADOPTION AND USE OF QUALITY MEASURES;**

19 **REPORTING.**

20 “(a) IN GENERAL.—For purposes of carrying out ac-
21 tivities authorized or required by this title to ensure the
22 use of quality measures and to foster uniformity between
23 health care quality measures utilized by private entities,
24 the Secretary shall—

1 “(1) select quality measures for adoption and
2 use, from quality measures recommended by multi-
3 stakeholder groups and endorsed by the designated
4 organization; and

5 “(2) ensure that standards adopted under sec-
6 tion 3003 integrate the quality measures endorsed,
7 adopted, and utilized under this section.

8 “(b) RELATIONSHIP WITH PROGRAMS UNDER THE
9 SOCIAL SECURITY ACT.—The Secretary shall ensure that
10 the quality measures adopted under this section—

11 “(1) complement quality measures developed by
12 the Secretary under programs administered by the
13 Secretary under the Social Security Act, including
14 programs under titles XVIII, XIX, and XXI of such
15 Act; and

16 “(2) do not conflict with the needs and prior-
17 ities of the programs under titles XVIII, XIX, and
18 XXI of such Act, as set forth by the Administrator
19 of the Centers for Medicare & Medicaid Services.

20 “(c) REPORTING.—The Secretary shall implement
21 procedures, consistent with generally accepted standards,
22 to enable the Department of Health and Human Services
23 to accept the electronic submission of data for purposes
24 of performance measurement, including at the provider

1 level, using the quality measures developed, endorsed, and
2 adopted pursuant to this title.

3 “(d) DISSEMINATION OF INFORMATION.—In order to
4 make comparative performance information available to
5 health care consumers, health professionals, public health
6 officials, oversight organizations, researchers, and other
7 appropriate individuals and entities, after consultation
8 with multi-stakeholder groups, the Secretary shall promul-
9 gate regulations to provide for the dissemination, aggrega-
10 tion, and analysis of quality measures collected pursuant
11 to this title.”.

12 **TITLE IV—PRIVACY AND** 13 **SECURITY**

14 **SEC. 401. PRIVACY AND SECURITY.**

15 Title XXX of the Public Health Service Act, as
16 amended by section 301, is further amended by adding
17 at the end the following:

18 **“SEC. 3012. ENSURING PRIVACY AND SECURITY.**

19 “(a) PRIVACY PROTECTIONS APPLY TO HEALTH IN-
20 FORMATION ELECTRONIC DATABASES.—An operator of a
21 health information electronic database shall be deemed to
22 be a ‘covered entity’ for purposes of sections 1171 through
23 1179 of the Social Security Act and the regulations pro-
24 mulgated under section 264(c) of the Health Insurance

1 Portability and Accountability Act of 1996 (referred to in
2 this section as the ‘HIPAA privacy regulations’).

3 “(b) HEALTH INFORMATION ELECTRONIC DATABASE
4 DEFINED.—In this section, the term ‘operator of a health
5 information electronic database’ means an entity that—

6 “(1) is constituted, organized, or chartered for
7 the primary purpose of maintaining or transmitting
8 protected health information in a designated record
9 set or sets;

10 “(2) receives valuable consideration for main-
11 taining or transmitting protected health information
12 in a designated record set or sets; and

13 “(3) is not a provider, a payer, a health care
14 clearinghouse or business associate of a covered enti-
15 ty as such terms are defined in the HIPAA privacy
16 regulations.

17 “(c) RIGHT OF INDIVIDUALS TO INSPECT THEIR
18 MEDICAL RECORDS MAINTAINED IN ELECTRONIC FOR-
19 MAT.—To the extent provided for under the HIPAA pri-
20 vacy regulations with respect to protected health informa-
21 tion, an individual shall have a right of access to inspect
22 and obtain a copy of protected health information about
23 the individual stored in electronic format.

24 “(d) RIGHTS OF INDIVIDUALS WHO ARE VICTIMS OF
25 MEDICAL FRAUD.—To the extent provided for under the

1 HIPAA privacy regulations and under the conditions spec-
2 ified in such regulations, with respect to protected health
3 information, an individual who is a victim of medical fraud
4 or who believes that there is an error in their protected
5 health information stored in an electronic format shall
6 have the right—

7 “(1) to have access to inspect and obtain a copy
8 of protected health information about the individual,
9 including the information fraudulently entered, in a
10 designated record set; and

11 “(2) to have a covered entity amend protected
12 health information or a record about the individual,
13 including information fraudulently entered, in a des-
14 ignated electronic record set for as long as the pro-
15 tected health information is maintained in the des-
16 ignated electronic record set to ensure that fraudu-
17 lent and inaccurate health information is not shared
18 or re-reported.

19 “(e) RIGHT OF INDIVIDUALS TO BE NOTIFIED FOL-
20 LOWING WRONGFUL DISCLOSURE.—In a manner con-
21 sistent with the HIPAA privacy regulations with respect
22 to accounting for disclosures of protected health informa-
23 tion, an individual shall have the right to be notified by
24 a covered entity if that covered entity wrongfully discloses
25 protected health information and the wrongful disclosure

1 is materially expected to result in medical fraud or identity
2 theft. The Secretary shall promulgate rules as necessary
3 to carry out this subsection.

4 “(f) **RULE OF CONSTRUCTION.**—Nothing in this sec-
5 tion shall be construed to supercede or otherwise limit the
6 provisions of any contract that provides for the application
7 of privacy protections that are greater than the privacy
8 protections provided for under the regulations promul-
9 gated under section 264 of the Health Insurance Port-
10 ability and Accountability Act of 1996.”.

11 **TITLE V—MISCELLANEOUS** 12 **PROVISIONS**

13 **SEC. 501. GAO STUDY.**

14 Not later than 9 months after the date of the enact-
15 ment of this Act, the Comptroller General of the United
16 States shall submit to Congress a report on the cir-
17 cumstances in which it is necessary and workable to re-
18 quire health plans (as defined in section 1171 of the Social
19 Security Act (42 U.S.C. 1320d)), health care clearing-
20 houses (as defined in such section 1171), and health care
21 providers (as defined in such section 1171) who transmit
22 health information in electronic form, to notify individuals
23 if their individually identifiable health information (as de-
24 fined in such section 1171) is wrongfully disclosed.

1 **SEC. 502. 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 (referred to in
11 this subsection as the ‘Center’) to provide technical
12 assistance and develop best practices to support and
13 accelerate efforts to adopt, implement, and effec-
14 tively use interoperable health information tech-
15 nology in compliance with sections 3003 and 3011.

16 “(2) PURPOSES.—The purposes of the Center
17 are to—

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

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

24 “(C) assemble, analyze, and widely dis-
25 seminate evidence and experience related to the

1 adoption, implementation, and effective use of
2 interoperable health information technology;

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

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

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

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

23 “(4) RULE OF CONSTRUCTION.—Nothing in
24 this subsection shall be construed to require the du-
25 plication of Federal efforts with respect to the estab-

1 lishment of the Center, regardless of whether such
2 efforts were carried out prior to or after the enact-
3 ment of this subsection.

4 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
5 are authorized to be appropriated such sums as may be
6 necessary for each of fiscal years 2008 and 2009 to carry
7 out this section.”.

8 **SEC. 503. FACILITATING THE PROVISION OF TELEHEALTH**
9 **SERVICES ACROSS STATE LINES.**

10 Section 330L of the Public Health Service Act (42
11 U.S.C. 254c–18) is amended to read as follows:

12 **“SEC. 330L. TELEMEDICINE; INCENTIVE GRANTS REGARD-**
13 **ING COORDINATION AMONG STATES.**

14 “(a) FACILITATING THE PROVISION OF TELE-
15 HEALTH SERVICES ACROSS STATE LINES.—The Sec-
16 retary may make grants to States that have adopted re-
17 gional State reciprocity agreements for practitioner licen-
18 sure, in order to expedite the provision of telehealth serv-
19 ices across State lines.

20 “(b) AUTHORIZATION OF APPROPRIATIONS.—For the
21 purpose of carrying out subsection (a), there are author-
22 ized to be appropriated such sums as may be necessary
23 for each of fiscal years 2008 through 2012.”.