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AN ACT

To promote a better health information system.

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 AND TABLE OF CONTENTS.**

4 (a) **SHORT TITLE.**—This Act may be cited as the
5 “Health Information Technology Promotion Act of 2006”.

6 (b) **TABLE OF CONTENTS.**—The table of contents of
7 this Act is as follows:

Sec. 1. Short title and table of contents.

Sec. 2. Preserving privacy and security laws.

TITLE I—COORDINATION FOR, PLANNING FOR, AND
INTEROPERABILITY OF HEALTH INFORMATION TECHNOLOGY

- Sec. 101. Office of the National Coordinator for Health Information Technology.
- Sec. 102. Report on the American Health Information Community.
- Sec. 103. Interoperability planning process; Federal information collection activities.
- Sec. 104. Grants to integrated health systems to promote health information technologies to improve coordination of care for the uninsured, underinsured, and medically underserved.
- Sec. 105. Small physician practice demonstration grants.

TITLE II—TRANSACTION STANDARDS, CODES, AND INFORMATION

- Sec. 201. Procedures to ensure timely updating of standards that enable electronic exchanges.
- Sec. 202. Upgrading ASC X12 and NCPDP standards.
- Sec. 203. Upgrading ICD codes; coding and documentation of non-medical information.
- Sec. 204. Strategic plan for coordinating implementation of transaction standards and ICD codes.
- Sec. 205. Study and report to determine impact of variation and commonality in State health information laws and regulations.
- Sec. 206. Report on appropriateness of classification methodologies and codes for additional purposes.

TITLE III—PROMOTING THE USE OF HEALTH INFORMATION
TECHNOLOGY TO BETTER COORDINATE HEALTH CARE

- Sec. 301. Safe harbors to antikickback civil penalties and criminal penalties for provision of health information technology and training services.
- Sec. 302. Exception to limitation on certain physician referrals (under Stark) for provision of health information technology and training services to health care professionals.
- Sec. 303. Rules of construction regarding use of consortia.

TITLE IV—ADDITIONAL PROVISIONS

- Sec. 401. Promotion of telehealth services.
- Sec. 402. Study and report on expansion of home health-related telehealth services.
- Sec. 403. Study and report on store and forward technology for telehealth.
- Sec. 404. Ensuring health care providers participating in PHSA programs, Medicaid, SCHIP, or the MCH program may maintain health information in electronic form.
- Sec. 405. Ensuring health care providers participating in the Medicare program may maintain health information in electronic form.
- Sec. 406. Study and report on State, regional, and community health information exchanges.
- Sec. 407. Promoting health information technology as a tool for chronic disease management.

1 **SEC. 2. PRESERVING PRIVACY AND SECURITY LAWS.**

2 Nothing in this Act (or the amendments made by this
3 Act) shall be construed to affect the scope, substance, or
4 applicability of section 264(c) of the Health Insurance
5 Portability and Accountability Act of 1996 and any regu-
6 lation issued pursuant to such section.

7 **TITLE I—COORDINATION FOR,**
8 **PLANNING FOR, AND INTER-**
9 **OPERABILITY OF HEALTH IN-**
10 **FORMATION TECHNOLOGY**

11 **SEC. 101. OFFICE OF THE NATIONAL COORDINATOR FOR**
12 **HEALTH INFORMATION TECHNOLOGY.**

13 (a) IN GENERAL.—Title II of the Public Health Serv-
14 ice Act is amended by adding at the end the following new
15 part:

16 **“PART D—HEALTH INFORMATION TECHNOLOGY**
17 **“SEC. 271. OFFICE OF THE NATIONAL COORDINATOR FOR**
18 **HEALTH INFORMATION TECHNOLOGY.**

19 “(a) ESTABLISHMENT.—There is established within
20 the Department of Health and Human Services an Office
21 of the National Coordinator for Health Information Tech-
22 nology that shall be headed by the National Coordinator
23 for Health Information Technology (referred to in this
24 part as the ‘National Coordinator’). The National Coordi-
25 nator shall be appointed by and report directly to the Sec-
26 retary. The National Coordinator shall be paid at a rate

1 equal to the rate of basic pay for level IV of the Executive
2 Schedule.

3 “(b) GOALS OF NATIONWIDE INTEROPERABLE
4 HEALTH INFORMATION TECHNOLOGY INFRASTRUC-
5 TURE.—The National Coordinator shall perform the du-
6 ties under subsection (c) in a manner consistent with the
7 development of a nationwide interoperable health informa-
8 tion technology infrastructure that—

9 “(1) improves health care quality, promotes
10 data accuracy, reduces medical errors, increases the
11 efficiency of care, and advances the delivery of ap-
12 propriate, evidence-based health care services;

13 “(2) promotes wellness, disease prevention, and
14 management of chronic illnesses by increasing the
15 availability and transparency of information related
16 to the health care needs of an individual for such in-
17 dividual;

18 “(3) promotes the availability of appropriate
19 and accurate information necessary to make medical
20 decisions in a usable form at the time and in the lo-
21 cation that the medical service involved is provided;

22 “(4) produces greater value for health care ex-
23 penditures by reducing health care costs that result
24 from inefficiency, medical errors, inappropriate care,
25 and incomplete or inaccurate information;

1 “(5) promotes a more effective marketplace,
2 greater competition, greater systems analysis, in-
3 creased consumer choice, enhanced quality, and im-
4 proved outcomes in health care services;

5 “(6) with respect to health information of con-
6 sumers, advances the portability of such information
7 and the ability of such consumers to share and use
8 such information to assist in the management of
9 their health care;

10 “(7) improves the coordination of information
11 and the provision of such services through an effec-
12 tive infrastructure for the secure and authorized ex-
13 change and use of health care information;

14 “(8) provides for the confidentiality and secu-
15 rity of individually identifiable health information,
16 consistent with legally applicable requirements with
17 respect to securing and protecting the confidentiality
18 of individually identifiable health information of a
19 patient;

20 “(9) promotes the creation and maintenance of
21 transportable, secure, Internet-based personal health
22 records, including promoting the efforts of health
23 care payers and health plan administrators for a
24 health plan, such as Federal agencies, private health

1 plans, and third party administrators, to provide for
2 such records on behalf of members of such a plan;

3 “(10) promotes access to and review of the elec-
4 tronic health record of a patient by such patient;

5 “(11) promotes health research and health care
6 quality research and assessment;

7 “(12) promotes the efficient and streamlined
8 development, submission, and maintenance of elec-
9 tronic health care clinical trial data; and

10 “(13) improves the availability of information
11 and resources for individuals with low or limited lit-
12 eracy or language skills.

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

14 “(1) STRATEGIC PLANNER FOR INTEROPER-
15 ABLE HEALTH INFORMATION TECHNOLOGY.—The
16 National Coordinator shall provide for a strategic
17 plan for the nationwide implementation of interoper-
18 able health information technology in both the public
19 and private health care sectors consistent with sub-
20 section (b).

21 “(2) PRINCIPAL ADVISOR TO THE SEC-
22 RETARY.—The National Coordinator shall serve as
23 the principal advisor to the Secretary on the develop-
24 ment, application, and use of health information
25 technology, and shall coordinate the policies and pro-

1 grams of the Department of Health and Human
2 Services for promoting the use of health information
3 technology.

4 “(3) INTRAGOVERNMENTAL COORDINATOR.—

5 The National Coordinator shall ensure that health
6 information technology policies and programs of the
7 Department of Health and Human Services are co-
8 ordinated with those of relevant executive branch
9 agencies and departments with a goal to avoid dupli-
10 cation of effort, to align the health information ar-
11 chitecture of each agency or department toward a
12 common approach, to ensure that each agency or de-
13 partment conducts programs within the areas of its
14 greatest expertise and its mission in order to create
15 a national interoperable health information system
16 capable of meeting national public health needs ef-
17 fectively and efficiently, and to assist Federal agen-
18 cies and departments in security programs, policies,
19 and protections to prevent unauthorized access to in-
20 dividually identifiable health information created,
21 maintained, or in the temporary possession of that
22 agency or department. The coordination authority
23 provided to the National Coordinator under the pre-
24 vious sentence shall supercede any such authority
25 otherwise provided to any other official of the De-

1 partment of Health and Human Services. For the
2 purposes of this paragraph, the term ‘unauthorized
3 access’ means access that is not authorized by that
4 agency or department including unauthorized em-
5 ployee access.

6 “(4) ADVISOR TO OMB.—The National Coordi-
7 nator shall provide to the Director of the Office of
8 Management and Budget comments and advice with
9 respect to specific Federal health information tech-
10 nology programs.

11 “(5) PROMOTER OF HEALTH INFORMATION
12 TECHNOLOGY IN MEDICALLY UNDERSERVED COMMU-
13 NITIES.—The National Coordinator shall—

14 “(A) identify sources of funds that will be
15 made available to promote and support the
16 planning and adoption of health information
17 technology in medically underserved commu-
18 nities, including in urban and rural areas, ei-
19 ther through grants or technical assistance;

20 “(B) coordinate with the funding sources
21 to help such communities connect to identified
22 funding; and

23 “(C) collaborate with the Agency for
24 Healthcare Research and Quality and the
25 Health Services Resources Administration and

1 other Federal agencies to support technical as-
2 sistance, knowledge dissemination, and resource
3 development, to medically underserved commu-
4 nities seeking to plan for and adopt technology
5 and establish electronic health information net-
6 works across providers.”.

7 (b) TREATMENT OF EXECUTIVE ORDER NO.
8 13335.—Executive Order No. 13335 shall not have any
9 force or effect after the date of the enactment of this Act.

10 (c) TRANSITION FROM ONCHIT UNDER EXECUTIVE
11 ORDER.—

12 (1) IN GENERAL.—All functions, personnel, as-
13 sets, liabilities, administrative actions, and statutory
14 reporting requirements applicable to the old Na-
15 tional Coordinator or the Office of the old National
16 Coordinator on the date before the date of the enact-
17 ment of this Act shall be transferred, and applied in
18 the same manner and under the same terms and
19 conditions, to the new National Coordinator and the
20 Office of the new National Coordinator as of the
21 date of the enactment of this Act.

22 (2) RULE OF CONSTRUCTION.— Nothing in this
23 section or the amendment made by this section shall
24 be construed as requiring the duplication of Federal
25 efforts with respect to the establishment of the Of-

1 fice of the National Coordinator for Health Informa-
2 tion Technology, regardless of whether such efforts
3 are carried out before or after the date of the enact-
4 ment of this Act.

5 (3) ACTING NATIONAL COORDINATOR.—Before
6 the appointment of the new National Coordinator,
7 the old National Coordinator shall act as the Na-
8 tional Coordinator for Health Information Tech-
9 nology until the office is filled as provided in section
10 271(a) of the Public Health Service Act, as added
11 by subsection (a). The Secretary of Health and
12 Human Services may appoint the old National Coor-
13 dinator as the new National Coordinator.

14 (4) DEFINITIONS.—For purposes of this sub-
15 section:

16 (A) NEW NATIONAL COORDINATOR.—The
17 term “new National Coordinator” means the
18 National Coordinator for Health Information
19 Technology appointed under section 271(a) of
20 the Public Health Service Act, as added by sub-
21 section (a).

22 (B) OLD NATIONAL COORDINATOR.—The
23 term “old National Coordinator” means the
24 National Coordinator for Health Information

1 Technology appointed under Executive Order
2 No. 13335.

3 (d) STUDY OF HEALTH INFORMATION TECHNOLOGY
4 IN MEDICALLY UNDERSERVED COMMUNITIES.—

5 (1) STUDY.—The National Coordinator for
6 Health Information Technology shall conduct a
7 study on the development and implementation of
8 health information technology in medically under-
9 served communities. The study shall—

10 (A) identify barriers to successful imple-
11 mentation of health information technology in
12 these communities;

13 (B) examine the impact of health informa-
14 tion technology on providing quality care and
15 reducing the cost of care to these communities;

16 (C) examine urban and rural community
17 health systems and determine the impact that
18 health information technology may have on the
19 capacity of primary health providers; and

20 (D) assess the feasibility and the costs of
21 associated with the use of health information
22 technology in these communities.

23 (2) REPORT.—Not later than 18 months after
24 the date of the enactment of this Act, the National
25 Coordinator shall submit to Congress a report on the

1 study conducted under paragraph (1) and shall in-
2 clude in such report such recommendations for legis-
3 lation or administrative action as the Coordinator
4 determines appropriate.

5 **SEC. 102. REPORT ON THE AMERICAN HEALTH INFORMA-**
6 **TION COMMUNITY.**

7 Not later than one year after the date of the enact-
8 ment of this Act, the Secretary of Health and Human
9 Services shall submit to Congress a report on the work
10 conducted by the American Health Information Commu-
11 nity (in this section referred to as “AHIC”), as established
12 by the Secretary. Such report shall include the following:

13 (1) A description of the accomplishments of
14 AHIC, with respect to the promotion of the develop-
15 ment of national guidelines, the development of a
16 nationwide health information network, and the in-
17 creased adoption of health information technology.

18 (2) Information on how model privacy and secu-
19 rity policies may be used to protect confidentiality of
20 health information, and an assessment of how exist-
21 ing policies compare to such model policies.

22 (3) Information on the progress in—

23 (A) establishing uniform industry-wide
24 health information technology standards;

1 (B) achieving an internet-based nationwide
2 health information network;

3 (C) achieving interoperable electronic
4 health record adoption across health care pro-
5 viders; and

6 (D) creating technological innovations to
7 promote security and confidentiality of individ-
8 ually identifiable health information.

9 (4) Recommendations for the transition of
10 AHIC to a longer-term or permanent advisory and
11 facilitation entity, including—

12 (A) a schedule for such transition;

13 (B) options for structuring the entity as ei-
14 ther a public-private or private sector entity;

15 (C) the collaborative role of the Federal
16 Government in the entity;

17 (D) steps for—

18 (i) continued leadership in the facilita-
19 tion of guidelines or standards;

20 (ii) the alignment of financial incen-
21 tives; and

22 (iii) the long-term plan for health care
23 transformation through information tech-
24 nology; and

1 (E) the elimination or revision of the func-
2 tions of AHIC during the development of the
3 nationwide health information network.

4 (5) Recommendations on the inclusion of emer-
5 gency contact or next-of-kin information (including
6 name and phone number) in interoperable electronic
7 health records.

8 **SEC. 103. INTEROPERABILITY PLANNING PROCESS; FED-**
9 **ERAL INFORMATION COLLECTION ACTIVI-**
10 **TIES.**

11 Part D of title II of the Public Health Service Act,
12 as added by section 101(a), is amended by adding at the
13 end the following new section:

14 **“SEC. 272. INTEROPERABILITY PLANNING PROCESS; FED-**
15 **ERAL INFORMATION COLLECTION ACTIVI-**
16 **TIES.**

17 “(a) STRATEGIC INTEROPERABILITY PLANNING
18 PROCESS.—

19 “(1) ASSESSMENT AND ENDORSEMENT OF
20 CORE STRATEGIC GUIDELINES.—

21 “(A) IN GENERAL.—Not later than De-
22 cember 31, 2006, the National Coordinator
23 shall publish a strategic plan, including a sched-
24 ule, for the assessment and the endorsement of
25 core interoperability guidelines for significant

1 use cases consistent with this subsection. The
2 National Coordinator may update such plan
3 from time to time.

4 “(B) ENDORSEMENT.—

5 “(i) IN GENERAL.—Consistent with
6 the schedule under this paragraph and not
7 later than one year after the publication of
8 such schedule, the National Coordinator
9 shall endorse a subset of core interoper-
10 ability guidelines for significant use cases.
11 The National Coordinator shall continue to
12 endorse subsets of core interoperability
13 guidelines for significant use cases annu-
14 ally consistent with the schedule published
15 pursuant to this paragraph, with endorse-
16 ment of all such guidelines completed not
17 later than August 31, 2009.

18 “(ii) CONSULTATION.—All such en-
19 dorsements shall be in consultation with
20 the American Health Information Commu-
21 nity and other appropriate entities.

22 “(iii) VOLUNTARY COMPLIANCE.—
23 Compliance with such guidelines shall be
24 voluntary, subject to subsection (b)(1).

1 “(C) CONSULTATION WITH OTHER PAR-
2 TIES.—The National Coordinator shall develop
3 and implement such strategic plan in consulta-
4 tion with the American Health Information
5 Community and other appropriate entities.

6 “(D) DEFINITIONS.—For purposes of this
7 section:

8 “(i) INTEROPERABILITY GUIDE-
9 LINE.—The term ‘interoperability guide-
10 line’ means a guideline to improve and pro-
11 mote the interoperability of health infor-
12 mation technology for purposes of elec-
13 tronically accessing and exchanging health
14 information. Such term includes named
15 standards, architectures, software schemes
16 for identification, authentication, and secu-
17 rity, and other information needed to en-
18 sure the reproducible development of com-
19 mon solutions across disparate entities.

20 “(ii) CORE INTEROPERABILITY GUIDE-
21 LINE.—The term ‘core interoperability
22 guideline’ means an interoperability guide-
23 line that the National Coordinator deter-
24 mines is essential and necessary for pur-
25 poses described in clause (i).

1 “(iii) SIGNIFICANT USE CASE.—The
2 term ‘significant use case’ means a cat-
3 egory (as specified by the National Coordi-
4 nator) that identifies a significant use or
5 purpose for the interoperability of health
6 information technology, such as for the ex-
7 change of laboratory information, drug
8 prescribing, clinical research, and elec-
9 tronic health records.

10 “(2) NATIONAL SURVEY.—

11 “(A) IN GENERAL.—Not later than August
12 31, 2008, the National Coordinator shall con-
13 duct one or more surveys designed to measure
14 the capability of entities (including Federal
15 agencies, State and local government agencies,
16 and private sector entities) to exchange elec-
17 tronic health information by appropriate signifi-
18 cant use case. Such surveys shall identify the
19 extent to which the type of health information,
20 the use for such information, or any other ap-
21 propriate characterization of such information
22 may relate to the capability of such entities to
23 exchange health information in a manner that
24 is consistent with methods to improve the inter-

1 operability of health information and with core
2 interoperability guidelines.

3 “(B) DISSEMINATION OF SURVEY RE-
4 SULTS.—The National Coordinator shall dis-
5 seminate the results of such surveys in a man-
6 ner so as to—

7 “(i) inform the public on the capabili-
8 ties of entities to exchange electronic
9 health information;

10 “(ii) assist in establishing a more
11 interoperable information architecture; and

12 “(iii) identify the status of health in-
13 formation systems used in Federal agen-
14 cies and the status of such systems with
15 respect to interoperability guidelines.

16 “(b) FEDERAL HEALTH INFORMATION COLLECTION
17 ACTIVITIES.—

18 “(1) REQUIREMENTS.—With respect to a core
19 interoperability guideline endorsed under subsection
20 (a)(1)(B) for a significant use case, the President
21 shall take measures to ensure that Federal activities
22 involving the broad collection and submission of
23 health information are consistent with such guideline
24 within three years after the date of such endorse-
25 ment.

1 “(2) PROMOTING USE OF NON-IDENTIFIABLE
2 HEALTH INFORMATION TO IMPROVE HEALTH RE-
3 SEARCH AND HEALTH CARE QUALITY.—

4 “(A) IN GENERAL.—Where feasible, and
5 consistent with applicable privacy or security or
6 other laws, the President, in consultation with
7 the Secretary, shall take measures to allow
8 timely access to useful categories of non-identi-
9 fiable health information in records maintained
10 by the Federal government, or maintained by
11 entities under contract with the Federal govern-
12 ment, to advance health care quality and health
13 research where such information is in a form
14 that can be used in such research. The Presi-
15 dent shall consult with appropriate Federal
16 agencies, and solicit public comment, on useful
17 categories of information, and appropriate
18 measures to take. The President may consider
19 the administrative burden and the potential for
20 improvements in health care quality in deter-
21 mining such appropriate measures. In addition,
22 the President, in consultation with the Sec-
23 retary, shall encourage voluntary private and
24 public sector efforts to allow access to such use-
25 ful categories of non-identifiable health infor-

1 mation to advance health care quality and
2 health research.

3 “(B) NON-IDENTIFIABLE HEALTH INFOR-
4 MATION DEFINED.—For purposes of this para-
5 graph, the term ‘non-identifiable health infor-
6 mation’ means information that is not individ-
7 ually identifiable health information as defined
8 in rules promulgated pursuant to section 264(c)
9 of the Health Insurance Portability and Ac-
10 countability Act of 1996 (42 U.S.C. 1320d–2
11 note), and includes information that has been
12 de-identified so that it is no longer individually
13 identifiable health information, as defined in
14 such rules.

15 “(3) ANNUAL REVIEW AND REPORT.—For each
16 year during the five-year period following the date of
17 the enactment of this section, the National Coordi-
18 nator shall review the operation of health informa-
19 tion collection by and submission to the Federal gov-
20 ernment and the purchases (and planned purchases)
21 of health information technology by the Federal gov-
22 ernment. For each such year and based on the re-
23 view for such year, the National Coordinator shall
24 submit to the President and Congress recommenda-
25 tions on methods to—

1 “(A) streamline (and eliminate redundancy
2 in) Federal systems used for the collection and
3 submission of health information;

4 “(B) improve efficiency in such collection
5 and submission;

6 “(C) increase the ability to assess health
7 care quality; and

8 “(D) reduce health care costs.”.

9 **SEC. 104. GRANTS TO INTEGRATED HEALTH SYSTEMS TO**
10 **PROMOTE HEALTH INFORMATION TECH-**
11 **NOLOGIES TO IMPROVE COORDINATION OF**
12 **CARE FOR THE UNINSURED, UNDERINSURED,**
13 **AND MEDICALLY UNDERSERVED.**

14 Subpart I of part D of title III of the Public Health
15 Service Act (42 U.S.C. 254b et seq.) is amended by adding
16 at the end the following:

17 **“SEC. 330M. GRANTS FOR IMPROVEMENT OF THE COORDI-**
18 **NATION OF CARE FOR THE UNINSURED,**
19 **UNDERINSURED, AND MEDICALLY UNDER-**
20 **SERVED.**

21 “(a) IN GENERAL.—The Secretary may make grants
22 to integrated health care systems, in accordance with this
23 section, for projects to better coordinate the provision of
24 health care through the adoption of new health informa-
25 tion technology, or the significant improvement of existing

1 health information technology, to improve the provision of
2 health care to uninsured, underinsured, and medically un-
3 derserved individuals (including in urban and rural areas)
4 through health-related information about such individuals,
5 throughout such a system and at the point of service.

6 “(b) ELIGIBILITY.—

7 “(1) APPLICATION.—To be eligible to receive a
8 grant under this section, an integrated health care
9 system shall prepare and submit to the Secretary an
10 application, at such time, in such manner, and con-
11 taining such information as the Secretary may re-
12 quire, including—

13 “(A) a description of the project that the
14 system will carry out using the funds provided
15 under the grant;

16 “(B) a description of the manner in which
17 the project funded under the grant will advance
18 the goal specified in subsection (a); and

19 “(C) a description of the populations to be
20 served by the adoption or improvement of
21 health information technology.

22 “(2) OPTIONAL REPORTING CONDITION.—The
23 Secretary may also condition the provision of a
24 grant to an integrated health care system under this
25 section for a project on the submission by such sys-

1 tem to the Secretary of a report on the impact of
2 the health information technology adopted (or im-
3 proved) under such project on the delivery of health
4 care and the quality of care (in accordance with ap-
5 plicable measures of such quality). Such report shall
6 be at such time and in such form and manner as
7 specified by the Secretary.

8 “(c) INTEGRATED HEALTH CARE SYSTEM DE-
9 FINED.—For purposes of this section, the term ‘integrated
10 health care system’ means a system of health care pro-
11 viders that is organized to provide care in a coordinated
12 fashion and has a demonstrated commitment to provide
13 uninsured, underinsured, and medically underserved indi-
14 viduals with access to such care.

15 “(d) PRIORITIES.—In making grants under this sec-
16 tion, the Secretary shall give priority to an integrated
17 health care system—

18 “(1) that can demonstrate past successful com-
19 munity-wide efforts to improve the quality of care
20 provided and the coordination of care for the unin-
21 sured, underinsured, and medically underserved;

22 “(2) if the project to be funded through such a
23 grant—

24 “(A) will improve the delivery of health
25 care and the quality of care provided; and

1 “(B) will demonstrate savings for State or
2 Federal health care benefits programs or enti-
3 ties legally obligated under Federal law to pro-
4 vide health care from the reduction of duplica-
5 tive health care services, administrative costs,
6 and medical errors; or

7 “(3) if the project to be funded through such a
8 grant will emphasize the improvement of access to
9 medical care and medical care for medically under-
10 served populations which are geographically isolated
11 or located in underserved urban areas.

12 “(e) LIMITATION, MATCHING REQUIREMENT, AND
13 CONDITIONS.—

14 “(1) LIMITATION ON USE OF FUNDS.—None of
15 the funds provided under a grant made under this
16 section may be used for a project providing for the
17 adoption or improvement of health information tech-
18 nology that is used exclusively for financial record
19 keeping, billing, or other non-clinical applications.

20 “(2) MATCHING REQUIREMENT.—To be eligible
21 for a grant under this section an integrated health
22 care system shall contribute non-Federal contribu-
23 tions to the costs of carrying out the project for
24 which the grant is awarded in an amount equal to

1 \$1 for each \$5 of Federal funds provided under the
2 grant.

3 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated to carry out this section
5 \$15,000,000 for each of fiscal years 2007 and 2008.”.

6 **SEC. 105. SMALL PHYSICIAN PRACTICE DEMONSTRATION**
7 **GRANTS.**

8 Part D of title II of the Public Health Service Act,
9 as added by section 101(a) and amended by section 103,
10 is amended by adding at the end the following new section:

11 **“SEC. 273. SMALL PHYSICIAN PRACTICE DEMONSTRATION**
12 **GRANTS.**

13 “(a) IN GENERAL.—The Secretary shall establish a
14 demonstration program under which the Secretary makes
15 grants to small physician practices (including such prac-
16 tices that furnish services to individuals with chronic ill-
17 nesses) that are located in rural areas or medically under-
18 served urban areas for the purchase and support of health
19 information technology.

20 “(b) ELIGIBILITY.—To be eligible to receive a grant
21 under this section, an applicant shall prepare and submit
22 to the Secretary an application, at such time, in such man-
23 ner, and containing such information, as the Secretary
24 may require.

25 “(c) REPORTING.—

1 “(1) REQUIRED REPORTS BY SMALL PHYSICIAN
2 PRACTICES.—A small physician practice receiving a
3 grant under subsection (a) shall submit to the Sec-
4 retary an evaluation on the health information tech-
5 nology funded by such grant. Such evaluation shall
6 include information on—

7 “(A) barriers to the adoption of health in-
8 formation technology by the small physician
9 practice;

10 “(B) issues for such practice in the use of
11 health information technology;

12 “(C) the effect health information tech-
13 nology will have on the quality of health care
14 furnished by such practice; and

15 “(D) the effect of any medical liability
16 rules on such practice.

17 “(2) REPORT TO CONGRESS.—Not later than
18 January 1, 2009, the Secretary shall submit to Con-
19 gress a report on the results of the demonstration
20 program under this section.

21 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
22 are authorized to be appropriated to carry out this section
23 \$5,000,000 for each of fiscal years 2007 and 2008.”.

1 **TITLE II—TRANSACTION STAND-**
2 **ARDS, CODES, AND INFORMA-**
3 **TION**

4 **SEC. 201. PROCEDURES TO ENSURE TIMELY UPDATING OF**
5 **STANDARDS THAT ENABLE ELECTRONIC EX-**
6 **CHANGES.**

7 Section 1174(b) of the Social Security Act (42 U.S.C.
8 1320d–3(b)) is amended—

9 (1) in paragraph (1)—

10 (A) in the first sentence, by inserting “and
11 in accordance with paragraph (3)” before the
12 period; and

13 (B) by adding at the end the following new
14 sentence: “For purposes of this subsection and
15 section 1173(c)(2), the term ‘modification’ in-
16 cludes a new version or a version upgrade.”;
17 and

18 (2) by adding at the end the following new
19 paragraph:

20 “(3) **EXPEDITED PROCEDURES FOR ADOPTION**
21 **OF ADDITIONS AND MODIFICATIONS TO STAND-**
22 **ARDS.—**

23 “(A) **IN GENERAL.—**For purposes of para-
24 graph (1), the Secretary shall provide for an ex-
25 pedited upgrade program (in this paragraph re-

1 ferred to as the ‘upgrade program’), in accord-
2 ance with this paragraph, to develop and ap-
3 prove additions and modifications to the stand-
4 ards adopted under section 1173(a) to improve
5 the quality of such standards or to extend the
6 functionality of such standards to meet evolving
7 requirements in health care.

8 “(B) PUBLICATION OF NOTICES.—Under
9 the upgrade program:

10 “(i) VOLUNTARY NOTICE OF INITI-
11 ATION OF PROCESS.—Not later than 30
12 days after the date the Secretary receives
13 a notice from a standard setting organiza-
14 tion that the organization is initiating a
15 process to develop an addition or modifica-
16 tion to a standard adopted under section
17 1173(a), the Secretary shall publish a no-
18 tice in the Federal Register that—

19 “(I) identifies the subject matter
20 of the addition or modification;

21 “(II) provides a description of
22 how persons may participate in the
23 development process; and

24 “(III) invites public participation
25 in such process.

1 “(ii) VOLUNTARY NOTICE OF PRE-
2 LIMINARY DRAFT OF ADDITIONS OR MODI-
3 FICATIONS TO STANDARDS.—Not later
4 than 30 days after the date of the date the
5 Secretary receives a notice from a standard
6 setting organization that the organization
7 has prepared a preliminary draft of an ad-
8 dition or modification to a standard adopt-
9 ed by section 1173(a), the Secretary shall
10 publish a notice in the Federal Register
11 that—

12 “(I) identifies the subject matter
13 of (and summarizes) the addition or
14 modification;

15 “(II) specifies the procedure for
16 obtaining the draft;

17 “(III) provides a description of
18 how persons may submit comments in
19 writing and at any public hearing or
20 meeting held by the organization on
21 the addition or modification; and

22 “(IV) invites submission of such
23 comments and participation in such
24 hearing or meeting without requiring
25 the public to pay a fee to participate.

1 “(iii) NOTICE OF PROPOSED ADDITION
2 OR MODIFICATION TO STANDARDS.—Not
3 later than 30 days after the date of the
4 date the Secretary receives a notice from a
5 standard setting organization that the or-
6 ganization has a proposed addition or
7 modification to a standard adopted under
8 section 1173(a) that the organization in-
9 tends to submit under subparagraph
10 (D)(iii), the Secretary shall publish a no-
11 tice in the Federal Register that contains,
12 with respect to the proposed addition or
13 modification, the information required in
14 the notice under clause (ii) with respect to
15 the addition or modification.

16 “(iv) CONSTRUCTION.—Nothing in
17 this paragraph shall be construed as re-
18 quiring a standard setting organization to
19 request the notices described in clauses (i)
20 and (ii) with respect to an addition or
21 modification to a standard in order to
22 qualify for an expedited determination
23 under subparagraph (C) with respect to a
24 proposal submitted to the Secretary for
25 adoption of such addition or modification.

1 “(C) PROVISION OF EXPEDITED DETER-
2 MINATION.—Under the upgrade program and
3 with respect to a proposal by a standard setting
4 organization for an addition or modification to
5 a standard adopted under section 1173(a), if
6 the Secretary determines that the standard set-
7 ting organization developed such addition or
8 modification in accordance with the require-
9 ments of subparagraph (D) and the National
10 Committee on Vital and Health Statistics rec-
11 ommends approval of such addition or modifica-
12 tion under subparagraph (E), the Secretary
13 shall provide for expedited treatment of such
14 proposal in accordance with subparagraph (F).

15 “(D) REQUIREMENTS.—The requirements
16 under this subparagraph with respect to a pro-
17 posed addition or modification to a standard by
18 a standard setting organization are the fol-
19 lowing:

20 “(i) REQUEST FOR PUBLICATION OF
21 NOTICE.—The standard setting organiza-
22 tion submits to the Secretary a request for
23 publication in the Federal Register of a no-
24 tice described in subparagraph (B)(iii) for
25 the proposed addition or modification.

1 “(ii) PROCESS FOR RECEIPT AND
2 CONSIDERATION OF PUBLIC COMMENT.—
3 The standard setting organization provides
4 for a process through which, after the pub-
5 lication of the notice referred to under
6 clause (i), the organization—

7 “(I) receives and responds to
8 public comments submitted on a time-
9 ly basis on the proposed addition or
10 modification before submitting such
11 proposed addition or modification to
12 the National Committee on Vital and
13 Health Statistics under clause (iii);

14 “(II) makes publicly available a
15 written explanation for its response in
16 the proposed addition or modification
17 to comments submitted on a timely
18 basis; and

19 “(III) makes public comments re-
20 ceived under clause (I) available, or
21 provides access to such comments, to
22 the Secretary.

23 “(iii) SUBMITTAL OF FINAL PRO-
24 POSED ADDITION OR MODIFICATION TO
25 NCVHS.—After completion of the process

1 under clause (ii), the standard setting or-
2 ganization submits the proposed addition
3 or modification to the National Committee
4 on Vital and Health Statistics for review
5 and consideration under subparagraph (E).
6 Such submission shall include information
7 on the organization’s compliance with the
8 notice and comment requirements (and re-
9 sponses to those comments) under clause
10 (ii).

11 “(E) HEARING AND RECOMMENDATIONS
12 BY NATIONAL COMMITTEE ON VITAL AND
13 HEALTH STATISTICS.—Under the upgrade pro-
14 gram, upon receipt of a proposal submitted by
15 a standard setting organization under subpara-
16 graph (D)(iii) for the adoption of an addition or
17 modification to a standard, the National Com-
18 mittee on Vital and Health Statistics shall pro-
19 vide notice to the public and a reasonable op-
20 portunity for public testimony at a hearing on
21 such addition or modification. The Secretary
22 may participate in such hearing in such capac-
23 ity (including presiding ex officio) as the Sec-
24 retary shall determine appropriate. Not later
25 than 120 days after the date of receipt of the

1 proposal, the Committee shall submit to the
2 Secretary its recommendation to adopt (or not
3 adopt) the proposed addition or modification.

4 “(F) DETERMINATION BY SECRETARY TO
5 ACCEPT OR REJECT NATIONAL COMMITTEE ON
6 VITAL AND HEALTH STATISTICS RECOMMENDA-
7 TION.—

8 “(i) TIMELY DETERMINATION.—

9 Under the upgrade program, if the Na-
10 tional Committee on Vital and Health Sta-
11 tistics submits to the Secretary a rec-
12 ommendation under subparagraph (E) to
13 adopt a proposed addition or modification,
14 not later than 90 days after the date of re-
15 ceipt of such recommendation the Sec-
16 retary shall make a determination to ac-
17 cept or reject the recommendation and
18 shall publish notice of such determination
19 in the Federal Register not later than 30
20 days after the date of the determination.

21 “(ii) CONTENTS OF NOTICE.—If the
22 determination is to reject the recommenda-
23 tion, such notice shall include the reasons
24 for the rejection. If the determination is to
25 accept the recommendation, as part of

1 such notice the Secretary shall promulgate
2 the modified standard (including the ac-
3 cepted proposed addition or modification
4 accepted) as a final rule under this sub-
5 section without any further notice or public
6 comment period.

7 “(iii) LIMITATION ON CONSIDER-
8 ATION.—The Secretary shall not consider a
9 proposal under this subparagraph unless
10 the Secretary determines that the require-
11 ments of subparagraph (D) (including pub-
12 lication of notice and opportunity for pub-
13 lic comment) have been met with respect to
14 the proposal.

15 “(G) EXEMPTION FROM PAPERWORK RE-
16 DUCATION ACT.—Chapter 35 of title 44, United
17 States Code, shall not apply to a final rule pro-
18 mulgated under subparagraph (F).

19 “(H) TREATMENT AS SATISFYING RE-
20 QUIREMENTS FOR NOTICE-AND-COMMENT.—
21 Any requirements under section 553 of title 5,
22 United States Code, relating to notice and an
23 opportunity for public comment with respect to
24 a final rule promulgated under subparagraph
25 (F) shall be treated as having been met by

1 meeting the requirements of the notice and op-
2 portunity for public comment provided under
3 provisions of subparagraphs (B)(iii), (D), and
4 (E).

5 “(I) NO JUDICIAL REVIEW.—A final rule
6 promulgated under subparagraph (F) shall not
7 be subject to judicial review.”.

8 **SEC. 202. UPGRADING ASC X12 AND NCPDP STANDARDS.**

9 (a) IN GENERAL.—The Secretary of Health and
10 Human Services shall provide by notice published in the
11 Federal Register for the following replacements of stand-
12 ards to apply to transactions occurring on or after April
13 1, 2009:

14 (1) ACCREDITED STANDARDS COMMITTEE X12
15 (ASC X12) STANDARD.—The replacement of the Ac-
16 credited Standards Committee X12 (ASC X12)
17 version 4010 adopted under section 1173(a) of such
18 Act (42 U.S.C. 1320d–2(a)) with the ASC X12
19 version 5010, as reviewed by the National Com-
20 mittee on Vital Health Statistics.

21 (2) NATIONAL COUNCIL FOR PRESCRIPTION
22 DRUG PROGRAMS (NCPDP) TELECOMMUNICATIONS
23 STANDARDS.—The replacement of the National
24 Council for Prescription Drug Programs (NCPDP)
25 Telecommunications Standards version 5.1 adopted

1 under section 1173(a) of such Act (42 U.S.C.
2 1320d–2(a)) with whichever is the latest version of
3 the NCPDP Telecommunications Standards that has
4 been approved by such Council and reviewed by the
5 National Committee on Vital Health Statistics as of
6 April 1, 2007.

7 (b) NO JUDICIAL REVIEW.—The implementation of
8 subsection (a), including the determination of the latest
9 version under subsection (a)(2), shall not be subject to ju-
10 dicial review.

11 **SEC. 203. UPGRADING ICD CODES; CODING AND DOCU-**
12 **MENTATION OF NON-MEDICAL INFORMA-**
13 **TION.**

14 (a) UPGRADING ICD CODES.—

15 (1) IN GENERAL.—The Secretary of Health and
16 Human Services shall provide by notice published in
17 the Federal Register for the replacement of the
18 International Classification of Diseases, 9th revision,
19 Clinical Modification (ICD–9-CM) under the regula-
20 tion promulgated under section 1173(e) of the Social
21 Security Act (42 U.S.C. 1320d–2(e)), including for
22 purposes of part A of title XVIII of such Act, with
23 both of the following:

1 (A) The International Classification of
2 Diseases, 10th revision, Clinical Modification
3 (ICD–10-CM).

4 (B) The International Classification of
5 Diseases, 10th revision, Procedure Coding Sys-
6 tem (ICD–10-PCS).

7 (2) APPLICATION.—The replacement made by
8 paragraph (1) shall apply, for purposes of section
9 1175(b)(2) of the Social Security Act (42 U.S.C.
10 1320d–4(b)(2)), to services furnished on or after Oc-
11 tober 1, 2010.

12 (3) RULES OF CONSTRUCTION.—Nothing in
13 paragraph (1) shall be construed—

14 (A) as affecting the application of classi-
15 fication methodologies or codes, such as CPT or
16 HCPCS codes, other than under the Inter-
17 national Classification of Diseases (ICD); or

18 (B) as superseding the authority of the
19 Secretary of Health and Human Services to
20 maintain and modify the coding set for ICD–
21 10-CM and ICD–10-PCS, including under the
22 amendments made by section 201.

23 (b) CODING AND DOCUMENTATION OF NON-MEDICAL
24 INFORMATION.—In any regulation or other action imple-
25 menting the International Classification of Diseases, 10th

1 revision, Clinical Modification (ICD–10-CM), the Inter-
2 national Classification of Diseases, 10th revision, Proce-
3 dure Coding System (ICD–10-PCS), or other version of
4 the International Classification of Diseases, 10th revision,
5 the Secretary of Health and Human Services shall ensure
6 that no health care provider is required to code to a level
7 of specificity that would require documentation of non-
8 medical information on the external cause of any given
9 type of injury.

10 **SEC. 204. STRATEGIC PLAN FOR COORDINATING IMPLE-**
11 **MENTATION OF TRANSACTION STANDARDS**
12 **AND ICD CODES.**

13 Not later than the date that is 180 days after the
14 date of the enactment of this Act, the Secretary of Health
15 and Human Services, in consultation with relevant public
16 and private entities, shall develop a strategic plan with re-
17 spect to the need for coordination in the implementation
18 of—

19 (1) transaction standards under section 1173(a)
20 of the Social Security Act, including modifications to
21 such standards under section 1174(b)(3) of such
22 Act, as added by section 201; and

23 (2) any updated versions of the International
24 Classification of Diseases (ICD), including the re-

1 placement of ICD–9 provided for under section
2 203(a).

3 **SEC. 205. STUDY AND REPORT TO DETERMINE IMPACT OF**
4 **VARIATION AND COMMONALITY IN STATE**
5 **HEALTH INFORMATION LAWS AND REGULA-**
6 **TIONS.**

7 Part C of title XI of the Social Security Act is amend-
8 ed by adding at the end the following new section:

9 “STUDY AND REPORT TO DETERMINE IMPACT OF VARI-
10 ATION AND COMMONALITY IN STATE HEALTH INFOR-
11 MATION LAWS AND REGULATIONS

12 “SEC. 1180. (a) STUDY.—For purposes of promoting
13 the development of a nationwide interoperable health in-
14 formation technology infrastructure consistent with sec-
15 tion 271(b) of the Public Health Service Act, the Sec-
16 retary shall conduct a study of the impact of variation in
17 State security and confidentiality laws and current Fed-
18 eral security and confidentiality standards on the timely
19 exchanges of health information in order to ensure the
20 availability of health information necessary to make med-
21 ical decisions at the location in which the medical care in-
22 volved is provided. Such study shall examine—

23 “(1)(A) the degree of variation and com-
24 monality among the requirements of such laws for
25 States; and

1 “(B) the degree of variation and commonality
2 between the requirements of such laws and the cur-
3 rent Federal standards;

4 “(2) insofar as there is variation among and be-
5 tween such requirements, the strengths and weak-
6 nesses of such requirements; and

7 “(3) the extent to which such variation may ad-
8 versely impact the secure, confidential, and timely
9 exchange of health information among States, the
10 Federal government, and public and private entities,
11 or may otherwise impact the reliability of such infor-
12 mation.

13 “(b) REPORT.—Not later than 18 months after the
14 date of the enactment of this section, the Secretary shall
15 submit to Congress a report on the study under subsection
16 (a) and shall include in such report the following:

17 “(1) ANALYSIS OF NEED FOR GREATER COM-
18 MONALITY.—A determination by the Secretary on
19 the extent to which there is a need for greater com-
20 monality of the requirements of State security and
21 confidentiality laws and current Federal security and
22 confidentiality standards to better protect, strength-
23 en, or otherwise improve the secure, confidential,
24 and timely exchange of health information among

1 States, the Federal government, and public and pri-
2 vate entities.

3 “(2) RECOMMENDATIONS FOR GREATER COM-
4 MONALITY.—Insofar as the Secretary determines
5 under paragraph (1) that there is a need for greater
6 commonality of such requirements, recommendations
7 on the extent to which (and how) the current Fed-
8 eral security and confidentiality standards should be
9 changed in order to provide the commonality needed
10 to better protect, strengthen, or otherwise improve
11 the secure, confidential, and timely exchange of
12 health information.

13 “(3) SPECIFIC RECOMMENDATION ON LEGISLA-
14 TIVE CHANGES FOR GREATER COMMONALITY.—A
15 specific recommendation on the extent to which and
16 how such standards should supersede State laws, in
17 order to provide the commonality needed to better
18 protect or strengthen the security and confidentiality
19 of health information in the timely exchange of such
20 information and legislative language in the form of
21 a bill to effectuate such specific recommendation.

22 “(c) CONGRESSIONAL CONSIDERATION OF LEGISLA-
23 TION PROVIDING FOR GREATER COMMONALITY.—

1 “(1) RULES OF HOUSE OF REPRESENTATIVES
2 AND SENATE.—This subsection is enacted by the
3 Congress—

4 “(A) as an exercise of the rulemaking
5 power of the House of Representatives and the
6 Senate, respectively, and as such they are
7 deemed a part of the rules of each House, re-
8 spectively, but applicable only with respect to
9 the procedure to be followed in that House in
10 the case of a greater commonality bill defined
11 in paragraph (4), and they supersede other
12 rules only to the extent that they are incon-
13 sistent therewith; and

14 “(B) with full recognition of the constitu-
15 tional right of either House to change the rules
16 (so far as relating to the procedure of that
17 House) at any time, in the same manner and
18 to the same extent as in the case of any other
19 rule of that House.

20 “(2) INTRODUCTION.—On the date on which
21 the final report is submitted under subsection
22 (b)(3)—

23 “(A) a greater commonality bill shall be in-
24 troduced (by request) in the House by the ma-
25 jority leader of the House, for himself and the

1 minority leader of the House, or by Members of
2 the House designated by the majority leader
3 and minority leader of the House; and

4 “(B) a greater commonality bill shall be
5 introduced (by request) in the Senate by the
6 majority leader of the Senate, for himself and
7 the minority leader of the Senate, or by Mem-
8 bers of the Senate designated by the majority
9 leader and minority leader of the Senate.

10 If either House is not in session on the day on which
11 such a report is submitted, the greater commonality
12 bill shall be introduced in that House, as provided
13 in the preceding sentence, on the first day thereafter
14 on which the House is in session.

15 “(3) REFERRAL.—A greater commonality bill
16 shall be referred by the Presiding Officers of the re-
17 spective House to the appropriate committee (or
18 committees) of such House, in accordance with the
19 rules of that House.

20 “(4) GREATER COMMONALITY BILL DEFINED.—
21 For purposes of this section, the term ‘greater com-
22 monality bill’ means a bill—

23 “(A) the title of which is the following: ‘A
24 Bill to provide the commonality needed to bet-
25 ter protect, strengthen, or otherwise improve

1 the secure, confidential, and timely exchange of
2 health information’; and

3 “(B) the text of which, as introduced, con-
4 sists of the text of the bill included in the re-
5 port submitted under subsection (b)(3).

6 “(d) DEFINITIONS.—For purposes of this section:

7 “(1) CURRENT FEDERAL SECURITY AND CON-
8 FIDENTIALITY STANDARDS.—The term ‘current Fed-
9 eral security and confidentiality standards’ means
10 the Federal privacy standards established pursuant
11 to section 264(c) of the Health Insurance Portability
12 and Accountability Act of 1996 (42 U.S.C. 1320d-
13 2 note) and security standards established under
14 section 1173(d) of the Social Security Act.

15 “(2) STATE.—The term ‘State’ has the mean-
16 ing given such term when used in title XI of the So-
17 cial Security Act, as provided under section 1101(a)
18 of such Act (42 U.S.C. 1301(a)).

19 “(3) STATE SECURITY AND CONFIDENTIALITY
20 LAWS.—The term ‘State security and confidentiality
21 laws’ means State laws and regulations relating to
22 the privacy and confidentiality of health information
23 or to the security of such information.”.

1 **SEC. 206. REPORT ON APPROPRIATENESS OF CLASSIFICA-**
2 **TION METHODOLOGIES AND CODES FOR AD-**
3 **DITIONAL PURPOSES.**

4 Not later than the date that is 180 days after the
5 date of the enactment of this Act, the Secretary of Health
6 and Human Services shall submit to Congress a report
7 that evaluates—

8 (1) the applicability of health care classification
9 methodologies and codes for purposes beyond the
10 coding of services for diagnostic documentation or
11 billing purposes;

12 (2) the usefulness, accuracy, and completeness
13 of such methodologies and codes for such purposes;
14 and

15 (3) the capacity of such methodologies and
16 codes to produce erroneous or misleading informa-
17 tion, with respect to such purposes.

1 **TITLE III—PROMOTING THE USE**
2 **OF HEALTH INFORMATION**
3 **TECHNOLOGY TO BETTER CO-**
4 **ORDINATE HEALTH CARE**

5 **SEC. 301. SAFE HARBORS TO ANTIKICKBACK CIVIL PEN-**
6 **ALTIES AND CRIMINAL PENALTIES FOR PRO-**
7 **VISION OF HEALTH INFORMATION TECH-**
8 **NOLOGY AND TRAINING SERVICES.**

9 (a) FOR CIVIL PENALTIES.—Section 1128A of the
10 Social Security Act (42 U.S.C. 1320a-7a) is amended—

11 (1) in subsection (b), by adding at the end the
12 following new paragraph:

13 “(4) For purposes of this subsection, inducements to
14 reduce or limit services described in paragraph (1) shall
15 not include the practical or other advantages resulting
16 from health information technology or related installation,
17 maintenance, support, or training services.”; and

18 (2) in subsection (i), by adding at the end the
19 following new paragraph:

20 “(8) The term ‘health information technology’
21 means hardware, software, license, right, intellectual
22 property, equipment, or other information tech-
23 nology (including new versions, upgrades, and
24 connectivity) designed or provided primarily for the
25 electronic creation, maintenance, or exchange of

1 health information to better coordinate care or im-
2 prove health care quality, efficiency, or research.”.

3 (b) FOR CRIMINAL PENALTIES.—Section 1128B of
4 such Act (42 U.S.C. 1320a-7b) is amended—

5 (1) in subsection (b)(3)—

6 (A) in subparagraph (G), by striking
7 “and” at the end;

8 (B) in the subparagraph (H) added by sec-
9 tion 237(d) of the Medicare Prescription Drug,
10 Improvement, and Modernization Act of 2003
11 (Public Law 108–173; 117 Stat. 2213)—

12 (i) by moving such subparagraph 2
13 ems to the left; and

14 (ii) by striking the period at the end
15 and inserting a semicolon;

16 (C) in the subparagraph (H) added by sec-
17 tion 431(a) of such Act (117 Stat. 2287)—

18 (i) by redesignating such subpara-
19 graph as subparagraph (I);

20 (ii) by moving such subparagraph 2
21 ems to the left; and

22 (iii) by striking the period at the end
23 and inserting “; and”; and

24 (D) by adding at the end the following new
25 subparagraph:

1 “(J) any nonmonetary remuneration (in the
2 form of health information technology, as defined in
3 section 1128A(i)(8), or related installation, mainte-
4 nance, support or training services) made to a per-
5 son by a specified entity (as defined in subsection
6 (g)) if—

7 “(i) the provision of such remuneration is
8 without an agreement between the parties or
9 legal condition that—

10 “(I) limits or restricts the use of the
11 health information technology to services
12 provided by the physician to individuals re-
13 ceiving services at the specified entity;

14 “(II) limits or restricts the use of the
15 health information technology in conjunc-
16 tion with other health information tech-
17 nology; or

18 “(III) conditions the provision of such
19 remuneration on the referral of patients or
20 business to the specified entity;

21 “(ii) such remuneration is arranged for in
22 a written agreement that is signed by the par-
23 ties involved (or their representatives) and that
24 specifies the remuneration solicited or received
25 (or offered or paid) and states that the provi-

1 sion of such remuneration is made for the pri-
2 mary purpose of better coordination of care or
3 improvement of health quality, efficiency, or re-
4 search; and

5 “(iii) the specified entity providing the re-
6 muneration (or a representative of such entity)
7 has not taken any action to disable any basic
8 feature of any hardware or software component
9 of such remuneration that would permit inter-
10 operability.”; and

11 (2) by adding at the end the following new sub-
12 section:

13 “(g) SPECIFIED ENTITY DEFINED.—For purposes of
14 subsection (b)(3)(J), the term ‘specified entity’ means an
15 entity that is a hospital, group practice, prescription drug
16 plan sponsor, a Medicare Advantage organization, or any
17 other such entity specified by the Secretary, considering
18 the goals and objectives of this section, as well as the goals
19 to better coordinate the delivery of health care and to pro-
20 mote the adoption and use of health information tech-
21 nology.”.

22 (c) EFFECTIVE DATE AND EFFECT ON STATE
23 LAWS.—

24 (1) EFFECTIVE DATE.—The amendments made
25 by subsections (a) and (b) shall take effect on the

1 date that is 120 days after the date of the enact-
2 ment of this Act.

3 (2) PREEMPTION OF STATE LAWS.—No State
4 (as defined in section 1101(a) of the Social Security
5 Act (42 U.S.C. 1301(a)) for purposes of title XI of
6 such Act) shall have in effect a State law that im-
7 poses a criminal or civil penalty for a transaction de-
8 scribed in section 1128A(b)(4) or section
9 1128B(b)(3)(J) of such Act, as added by subsections
10 (a)(1) and (b), respectively, if the conditions de-
11 scribed in the respective provision, with respect to
12 such transaction, are met.

13 (d) STUDY AND REPORT TO ASSESS EFFECT OF
14 SAFE HARBORS ON HEALTH SYSTEM.—

15 (1) IN GENERAL.—The Secretary of Health and
16 Human Services shall conduct a study to determine
17 the impact of each of the safe harbors described in
18 paragraph (3). In particular, the study shall examine
19 the following:

20 (A) The effectiveness of each safe harbor
21 in increasing the adoption of health information
22 technology.

23 (B) The types of health information tech-
24 nology provided under each safe harbor.

1 (C) The extent to which the financial or
2 other business relationships between providers
3 under each safe harbor have changed as a re-
4 sult of the safe harbor in a way that adversely
5 affects or benefits the health care system or
6 choices available to consumers.

7 (D) The impact of the adoption of health
8 information technology on health care quality,
9 cost, and access under each safe harbor.

10 (2) REPORT.—Not later than three years after
11 the effective date described in subsection (c)(1), the
12 Secretary of Health and Human Services shall sub-
13 mit to Congress a report on the study under para-
14 graph (1).

15 (3) SAFE HARBORS DESCRIBED.—For purposes
16 of paragraphs (1) and (2), the safe harbors de-
17 scribed in this paragraph are—

18 (A) the safe harbor under section
19 1128A(b)(4) of such Act (42 U.S.C. 1320a-
20 7a(b)(4)), as added by subsection (a)(1); and

21 (B) the safe harbor under section
22 1128B(b)(3)(J) of such Act (42 U.S.C. 1320a-
23 7b(b)(3)(J)), as added by subsection (b).

1 **SEC. 302. EXCEPTION TO LIMITATION ON CERTAIN PHYSI-**
2 **CIAN REFERRALS (UNDER STARK) FOR PRO-**
3 **VISION OF HEALTH INFORMATION TECH-**
4 **NOLOGY AND TRAINING SERVICES TO**
5 **HEALTH CARE PROFESSIONALS.**

6 (a) IN GENERAL.—Section 1877(b) of the Social Se-
7 curity Act (42 U.S.C. 1395nn(b)) is amended by adding
8 at the end the following new paragraph:

9 “(6) INFORMATION TECHNOLOGY AND TRAIN-
10 ING SERVICES.—

11 “(A) IN GENERAL.—Any nonmonetary re-
12 munerated (in the form of health information
13 technology or related installation, maintenance,
14 support or training services) made by a speci-
15 fied entity to a physician if—

16 “(i) the provision of such remunera-
17 tion is without an agreement between the
18 parties or legal condition that—

19 “(I) limits or restricts the use of
20 the health information technology to
21 services provided by the physician to
22 individuals receiving services at the
23 specified entity;

24 “(II) limits or restricts the use of
25 the health information technology in

1 conjunction with other health informa-
2 tion technology; or

3 “(III) conditions the provision of
4 such remuneration on the referral of
5 patients or business to the specified
6 entity;

7 “(ii) such remuneration is arranged
8 for in a written agreement that is signed
9 by the parties involved (or their represent-
10 atives) and that specifies the remuneration
11 made and states that the provision of such
12 remuneration is made for the primary pur-
13 pose of better coordination of care or im-
14 provement of health quality, efficiency, or
15 research; and

16 “(iii) the specified entity (or a rep-
17 resentative of such entity) has not taken
18 any action to disable any basic feature of
19 any hardware or software component of
20 such remuneration that would permit
21 interoperability.

22 “(B) HEALTH INFORMATION TECHNOLOGY
23 DEFINED.—For purposes of this paragraph, the
24 term ‘health information technology’ means
25 hardware, software, license, right, intellectual

1 property, equipment, or other information tech-
2 nology (including new versions, upgrades, and
3 connectivity) designed or provided primarily for
4 the electronic creation, maintenance, or ex-
5 change of health information to better coordi-
6 nate care or improve health care quality, effi-
7 ciency, or research.

8 “(C) SPECIFIED ENTITY DEFINED.—For
9 purposes of this paragraph, the term ‘specified
10 entity’ means an entity that is a hospital, group
11 practice, prescription drug plan sponsor, a
12 Medicare Advantage organization, or any other
13 such entity specified by the Secretary, consid-
14 ering the goals and objectives of this section, as
15 well as the goals to better coordinate the deliv-
16 ery of health care and to promote the adoption
17 and use of health information technology.”.

18 (b) EFFECTIVE DATE; EFFECT ON STATE LAWS.—

19 (1) EFFECTIVE DATE.—The amendment made
20 by subsection (a) shall take effect on the date that
21 is 120 days after the date of the enactment of this
22 Act.

23 (2) PREEMPTION OF STATE LAWS.—No State
24 (as defined in section 1101(a) of the Social Security
25 Act (42 U.S.C. 1301(a)) for purposes of title XI of

1 such Act) shall have in effect a State law that im-
2 poses a criminal or civil penalty for a transaction de-
3 scribed in section 1877(b)(6) of such Act, as added
4 by subsection (a), if the conditions described in such
5 section, with respect to such transaction, are met.

6 (c) STUDY AND REPORT TO ASSESS EFFECT OF EX-
7 CEPTION ON HEALTH SYSTEM.—

8 (1) IN GENERAL.—The Secretary of Health and
9 Human Services shall conduct a study to determine
10 the impact of the exception under section 1877(b)(6)
11 of such Act (42 U.S.C. 1395m(b)(6)), as added by
12 subsection (a). In particular, the study shall examine
13 the following:

14 (A) The effectiveness of the exception in
15 increasing the adoption of health information
16 technology.

17 (B) The types of health information tech-
18 nology provided under the exception.

19 (C) The extent to which the financial or
20 other business relationships between providers
21 under the exception have changed as a result of
22 the exception in a way that adversely affects or
23 benefits the health care system or choices avail-
24 able to consumers.

1 (D) The impact of the adoption of health
2 information technology on health care quality,
3 cost, and access under the exception.

4 (2) REPORT.—Not later than three years after
5 the effective date described in subsection (b)(1), the
6 Secretary of Health and Human Services shall sub-
7 mit to Congress a report on the study under para-
8 graph (1).

9 **SEC. 303. RULES OF CONSTRUCTION REGARDING USE OF**
10 **CONSORTIA.**

11 (a) APPLICATION TO SAFE HARBOR FROM CRIMINAL
12 PENALTIES.—Section 1128B(b)(3) of the Social Security
13 Act (42 U.S.C. 1320a–7b(b)(3)) is amended by adding
14 after and below subparagraph (J), as added by section
15 301(b)(1), the following: “For purposes of subparagraph
16 (J), nothing in such subparagraph shall be construed as
17 preventing a specified entity, consistent with the specific
18 requirements of such subparagraph, from forming a con-
19 sortium composed of health care providers, payers, em-
20 ployers, and other interested entities to collectively pur-
21 chase and donate health information technology, or from
22 offering health care providers a choice of health informa-
23 tion technology products in order to take into account the
24 varying needs of such providers receiving such products.”.

1 (b) APPLICATION TO STARK EXCEPTION.—Para-
 2 graph (6) of section 1877(b) of the Social Security Act
 3 (42 U.S.C. 1395m(b)), as added by section 302(a), is
 4 amended by adding at the end the following new subpara-
 5 graph:

6 “(D) RULE OF CONSTRUCTION.—For pur-
 7 poses of subparagraph (A), nothing in such
 8 subparagraph shall be construed as preventing
 9 a specified entity, consistent with the specific
 10 requirements of such subparagraph, from—

11 “(i) forming a consortium composed
 12 of health care providers, payers, employers,
 13 and other interested entities to collectively
 14 purchase and donate health information
 15 technology; or

16 “(ii) offering health care providers a
 17 choice of health information technology
 18 products in order to take into account the
 19 varying needs of such providers receiving
 20 such products.”.

21 **TITLE IV—ADDITIONAL** 22 **PROVISIONS**

23 **SEC. 401. PROMOTION OF TELEHEALTH SERVICES.**

24 (a) FACILITATING THE PROVISION OF TELEHEALTH
 25 SERVICES ACROSS STATE LINES.—The Secretary of

1 Health and Human Services shall, in coordination with
2 physicians, health care practitioners, patient advocates,
3 and representatives of States, encourage and facilitate the
4 adoption of State reciprocity agreements for practitioner
5 licensure in order to expedite the provision across State
6 lines of telehealth services.

7 (b) REPORT.—Not later than 18 months after the
8 date of the enactment of this Act, the Secretary of Health
9 and Human Services shall submit to Congress a report
10 on the actions taken to carry out subsection (a).

11 (c) STATE DEFINED.—For purposes of this sub-
12 section, the term “State” has the meaning given that term
13 for purposes of title XVIII of the Social Security Act.

14 **SEC. 402. STUDY AND REPORT ON EXPANSION OF HOME**
15 **HEALTH-RELATED TELEHEALTH SERVICES.**

16 (a) STUDY.—The Secretary of Health and Human
17 Services shall conduct a study to determine the feasibility,
18 advisability, and the costs of—

19 (1) including coverage and payment for home
20 health-related telehealth services as part of home
21 health services under title XVIII of the Social Secu-
22 rity Act; and

23 (2) expanding the list of sites described in para-
24 graph (4)(C)(ii) of section 1834(m) of the Social Se-
25 curity Act (42 U.S.C. 1395m(m)) to include county

1 mental health clinics or other publicly funded mental
2 health facilities for the purpose of payment under
3 such section for the provision of telehealth services
4 at such clinics or facilities.

5 (b) SPECIFICS OF STUDY.—Such study shall dem-
6 onstrate whether the changes described in paragraphs (1)
7 and (2) of subsection (a) will result in the following:

8 (1) Enhanced health outcomes for individuals
9 with one or more chronic conditions.

10 (2) Health outcomes for individuals furnished
11 telehealth services or home health-related telehealth
12 services that are at least comparable to the health
13 outcomes for individuals furnished similar items and
14 services by a health care provider at the same loca-
15 tion of the individual or at the home of the indi-
16 vidual, respectively.

17 (3) Facilitation of communication of more accu-
18 rate clinical information between health care pro-
19 viders.

20 (4) Closer monitoring of individuals by health
21 care providers.

22 (5) Overall reduction in expenditures for health
23 care items and services.

24 (6) Improved access to health care.

1 (c) HOME HEALTH-RELATED TELEHEALTH SERV-
2 ICES DEFINED.—For purposes of this section, the term
3 “home health-related telehealth services” means tech-
4 nology-based professional consultations, patient moni-
5 toring, patient training services, clinical observation, pa-
6 tient assessment, and any other health services that utilize
7 telecommunications technologies. Such term does not in-
8 clude a telecommunication that consists solely of a tele-
9 phone audio conversation, facsimile, electronic text mail,
10 or consultation between two health care providers.

11 (d) REPORT.—Not later than 18 months after the
12 date of the enactment of this Act, the Secretary of Health
13 and Human Services shall submit to Congress a report
14 on the study conducted under subsection (a) and shall in-
15 clude in such report such recommendations for legislation
16 or administration action as the Secretary determines ap-
17 propriate.

18 **SEC. 403. STUDY AND REPORT ON STORE AND FORWARD**
19 **TECHNOLOGY FOR TELEHEALTH.**

20 (a) STUDY.—The Secretary of Health and Human
21 Services, acting through the Director of the Office for the
22 Advancement of Telehealth, shall conduct a study on the
23 use of store and forward technologies (that provide for the
24 asynchronous transmission of health care information in
25 single or multimedia formats) in the provision of tele-

1 health services. Such study shall include an assessment of
2 the feasibility, advisability, and the costs of expanding the
3 use of such technologies for use in the diagnosis and treat-
4 ment of certain conditions.

5 (b) REPORT.—Not later than 18 months after the
6 date of the enactment of this Act, the Secretary of Health
7 and Human Services shall submit to Congress a report
8 on the study conducted under subsection (a) and shall in-
9 clude in such report such recommendations for legislation
10 or administration action as the Secretary determines ap-
11 propriate.

12 **SEC. 404. ENSURING HEALTH CARE PROVIDERS PARTICI-**
13 **PATING IN PHSA PROGRAMS, MEDICAID,**
14 **SCHIP, OR THE MCH PROGRAM MAY MAIN-**
15 **TAIN HEALTH INFORMATION IN ELECTRONIC**
16 **FORM.**

17 Part D of title II of the Public Health Service Act,
18 as added by section 101(a) and amended by sections 103
19 and 105, is further amended by adding at the end the
20 following new section:

21 **“SEC. 274. ENSURING HEALTH CARE PROVIDERS MAY MAIN-**
22 **TAIN HEALTH INFORMATION IN ELECTRONIC**
23 **FORM.**

24 “(a) IN GENERAL.—Any health care provider that
25 participates in a health care program that receives Federal

1 funds under this Act, or under title V, XIX, or XXI of
2 the Social Security Act, shall be deemed as meeting any
3 requirement for the maintenance of data in paper form
4 under such program (whether or not for purposes of man-
5 agement, billing, reporting, reimbursement, or otherwise)
6 if the required data is maintained in an electronic form.

7 “(b) RELATION TO STATE LAWS.—Beginning on the
8 date that is one year after the date of the enactment of
9 this section, subsection (a) shall supersede any contrary
10 provision of State law.

11 “(c) CONSTRUCTION.—Nothing in this section shall
12 be construed as—

13 “(1) requiring health care providers to maintain
14 or submit data in electronic form;

15 “(2) preventing a State from permitting health
16 care providers to maintain or submit data in paper
17 form; or

18 “(3) preventing a State from requiring health
19 care providers to maintain or submit data in elec-
20 tronic form.”.

1 **SEC. 405. ENSURING HEALTH CARE PROVIDERS PARTICI-**
2 **PATING IN THE MEDICARE PROGRAM MAY**
3 **MAINTAIN HEALTH INFORMATION IN ELEC-**
4 **TRONIC FORM.**

5 Section 1871 of the Social Security Act (42 U.S.C.
6 1395hh) is amended by adding at the end the following
7 new subsection:

8 “(g)(1) Any provider of services or supplier shall be
9 deemed as meeting any requirement for the maintenance
10 of data in paper form under this title (whether or not for
11 purposes of management, billing, reporting, reimburse-
12 ment, or otherwise) if the required data is maintained in
13 an electronic form.

14 “(2) Nothing in this subsection shall be construed as
15 requiring health care providers to maintain or submit data
16 in electronic form.”.

17 **SEC. 406. STUDY AND REPORT ON STATE, REGIONAL, AND**
18 **COMMUNITY HEALTH INFORMATION EX-**
19 **CHANGES.**

20 (a) STUDY.—The Secretary of Health and Human
21 Services shall conduct a study on issues related to the de-
22 velopment, operation, and implementation of State, re-
23 gional, and community health information exchanges.
24 Such study shall include the following, with respect to
25 such health information exchanges:

1 (1) Profiles detailing the current stages of such
2 health information exchanges with respect to the
3 progression of the development, operation, imple-
4 mentation, organization, and governance of such ex-
5 changes.

6 (2) The impact of such exchanges on healthcare
7 quality, safety, and efficiency, including—

8 (A) any impact on the coordination of
9 health information and services across
10 healthcare providers and other organizations
11 relevant to health care;

12 (B) any impact on the availability of health
13 information at the point-of-care to make timely
14 medical decisions;

15 (C) any benefits with respect to the pro-
16 motion of wellness, disease prevention, and
17 chronic disease management;

18 (D) any improvement with respect to pub-
19 lic health preparedness and response;

20 (E) any impact on the widespread adoption
21 of interoperable health information technology,
22 including electronic health records;

23 (F) any contributions to achieving an
24 Internet-based national health information net-
25 work;

1 (G) any contribution of health information
2 exchanges to consumer access and to con-
3 sumers' use of their health information; and

4 (H) any impact on the operation of—

5 (i) the Medicaid and Medicare pro-
6 grams;

7 (ii) the State Children's Health Insur-
8 ance Program (SCHIP);

9 (iii) disproportionate share hospitals
10 described in section 1923 of the Social Se-
11 curity Act;

12 (iv) Federally-qualified health centers;

13 or

14 (v) managed care plans, if a signifi-
15 cant number of the plan's enrollees are
16 beneficiaries in the Medicaid program or
17 SCHIP.

18 (3) Best practice models for financing,
19 incentivizing, and sustaining such health information
20 exchanges.

21 (4) Information identifying the common prin-
22 ciples, policies, tools, and standards used (or pro-
23 posed) in the public and private sectors to support
24 the development, operation, and implementation of
25 such health information exchanges.

1 (5) A description of any areas in which Federal
2 government leadership is needed to support growth
3 and sustainability of such health information ex-
4 changes.

5 (b) REPORT.—Not later than one year after the date
6 of enactment of this Act, the Secretary of Health and
7 Human Services shall submit to Congress a report on the
8 study described in subsection (a), including such rec-
9 ommendations as the Secretary determines appropriate to
10 facilitate the development, operation, and implementation
11 of health information exchanges.

12 **SEC. 407. PROMOTING HEALTH INFORMATION TECH-**
13 **NOLOGY AS A TOOL FOR CHRONIC DISEASE**
14 **MANAGEMENT.**

15 (a) IN GENERAL.—The Secretary of Health and
16 Human Services shall establish a two-year project to dem-
17 onstrate the impact of health information technology on
18 disease management for individuals entitled to medical as-
19 sistance under a State plan under title XIX of the Social
20 Security Act.

21 (b) STRUCTURE OF PROJECT.—The project under
22 subsection (a) shall—

23 (1) create a web-based virtual case management
24 tool that provides access to best practices for man-
25 aging chronic disease; and

1 (2) provide chronic disease patients and care-
2 givers access to their own medical records and to a
3 single source of information on chronic disease.

4 (c) COMPETITION.—Not later than the date that is
5 90 days after the date of the enactment of this Act, the
6 Secretary of Health and Human Services shall seek pro-
7 posals from States to carry out the project under sub-
8 section (a). The Secretary shall select not less than four
9 of such proposals submitted, and at least one proposal se-
10 lected shall include a regional approach that features ac-
11 cess to an integrated hospital information system in at
12 least two adjoining States and that permits the measure-
13 ment of health outcomes.

14 (d) REPORT.—Not later than the date that is 90 days
15 after the last day of the project under subsection (a), the
16 Secretary of Health and Human Services shall submit to
17 Congress a report on such project and shall include in
18 such report the amount of any cost-savings resulting from
19 the project and such recommendations for legislation or
20 administrative action as the Secretary determines appro-
21 priate.

Passed the House of Representatives July 27, 2006.

Attest:

KAREN L. HAAS,

Clerk.

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109TH CONGRESS
2^D SESSION

H. R. 4157

AN ACT

To promote a better health information system.

SEPTEMBER 5, 2006

Read the second time and placed on the calendar