

109TH CONGRESS
1ST SESSION

S. 1418

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 18, 2005

Referred to the Committee on Energy and Commerce

AN ACT

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

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

3 **SECTION 1. SHORT TITLE.**

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

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

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

5 **“TITLE XXIX—HEALTH INFORMA-**
 6 **TION TECHNOLOGY AND**
 7 **QUALITY**

8 **“SEC. 2901. DEFINITIONS.**

9 “In this title:

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

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

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

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

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

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

12 “(4) 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 “(5) LABORATORY.—The term ‘laboratory’ has
17 the meaning given that term in section 353.

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

21 “(7) QUALIFIED HEALTH INFORMATION TECH-
22 NOLOGY.—The term ‘qualified health information
23 technology’ means a computerized system (including
24 hardware and software) that—

1 “(A) protects the privacy and security of
2 health information;

3 “(B) maintains and provides permitted ac-
4 cess to health information in an electronic for-
5 mat;

6 “(C) incorporates decision support to re-
7 duce medical errors and enhance health care
8 quality;

9 “(D) complies with the standards adopted
10 by the Federal Government under section 2903;
11 and

12 “(E) allows for the reporting of quality
13 measures under section 2907.

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

18 **“SEC. 2902. OFFICE OF THE NATIONAL COORDINATOR OF**
19 **HEALTH INFORMATION TECHNOLOGY.**

20 “(a) OFFICE OF NATIONAL HEALTH INFORMATION
21 TECHNOLOGY.—There is established within the Office of
22 the Secretary an Office of the National Coordinator of
23 Health Information Technology (referred to in this section
24 as the ‘Office’). The Office shall be headed by a National

1 Coordinator who shall be appointed by the Secretary and
2 shall report directly to the Secretary.

3 “(b) PURPOSE.—It shall be the purpose of the Office
4 to coordinate with relevant Federal agencies and private
5 entities and oversee programs and activities to develop a
6 nationwide interoperable health information technology in-
7 frastructure that—

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

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

13 “(3) reduces health care costs resulting from
14 inefficiency, medical errors, inappropriate care, and
15 incomplete information;

16 “(4) ensures that appropriate information to
17 help guide medical decisions is available at the time
18 and place of care;

19 “(5) promotes a more effective marketplace,
20 greater competition, and increased choice through
21 the wider availability of accurate information on
22 health care costs, quality, and outcomes;

23 “(6) improves the coordination of care and in-
24 formation among hospitals, laboratories, physician
25 offices, and other entities through an effective infra-

1 structure for the secure and authorized exchange of
2 health care information;

3 “(7) improves public health reporting and facili-
4 tates the early identification and rapid response to
5 public health threats and emergencies, including bio-
6 terror events and infectious disease outbreaks;

7 “(8) facilitates health research; and

8 “(9) promotes prevention of chronic diseases.

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

10 The National Coordinator shall—

11 “(1) serve as the principal advisor to the Sec-
12 retary concerning the development, application, and
13 use of health information technology, and coordinate
14 and oversee the health information technology pro-
15 grams of the Department;

16 “(2) facilitate the adoption of a nationwide,
17 interoperable system for the electronic exchange of
18 health information;

19 “(3) ensure the adoption and implementation of
20 standards for the electronic exchange of health infor-
21 mation to reduce cost and improve health care qual-
22 ity;

23 “(4) ensure that health information technology
24 policy and programs of the Department are coordi-
25 nated with those of relevant executive branch agen-

1 cies (including Federal commissions) with a goal of
2 avoiding duplication of efforts and of helping to en-
3 sure that each agency undertakes health information
4 technology activities primarily within the areas of its
5 greatest expertise and technical capability;

6 “(5) to the extent permitted by law, coordinate
7 outreach and consultation by the relevant executive
8 branch agencies (including Federal commissions)
9 with public and private parties of interest, including
10 consumers, payers, employers, hospitals and other
11 health care providers, physicians, community health
12 centers, laboratories, vendors and other stake-
13 holders;

14 “(6) advise the President regarding specific
15 Federal health information technology programs;
16 and

17 “(7) prepare the reports described under sec-
18 tion 2903(i) (excluding paragraph (4) of such sec-
19 tion).

20 “(d) **DETAIL OF FEDERAL EMPLOYEES.—**

21 “(1) **IN GENERAL.—**Upon the request of the
22 National Coordinator, the head of any Federal agen-
23 cy is authorized to detail, with or without reimburse-
24 ment from the Office, any of the personnel of such

1 agency to the Office to assist it in carrying out its
2 duties under this section.

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

5 “(A) not interrupt or otherwise affect the
6 civil service status or privileges of the Federal
7 employee; and

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

11 “(3) ACCEPTANCE OF DETAILEES.—Notwith-
12 standing any other provision of law, the Office may
13 accept detailed personnel from other Federal agen-
14 cies without regard to whether the agency described
15 under paragraph (1) is reimbursed.

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

21 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
22 are authorized to be appropriated to carry out this section,
23 \$5,000,000 for fiscal year 2006, \$5,000,000 for fiscal year
24 2007, and such sums as may be necessary for each of fis-
25 cal years 2008 through 2010.

1 **“SEC. 2903. AMERICAN HEALTH INFORMATION COLLABO-**
2 **RATIVE.**

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

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

9 “(2) serve as a forum for the participation of
10 a broad range of stakeholders to provide input on
11 achieving the interoperability of health information
12 technology; and

13 “(3) recommend standards (including content,
14 communication, and security standards) for the elec-
15 tronic exchange of health information (including for
16 the reporting of quality data under section 2907) for
17 adoption by the Federal Government and voluntary
18 adoption by private entities.

19 “(b) COMPOSITION.—

20 “(1) IN GENERAL.—The Collaborative shall be
21 composed of members of the public and private sec-
22 tors to be appointed by the Secretary, including rep-
23 resentatives from—

24 “(A) consumer or patient organizations;

25 “(B) organizations with expertise in pri-
26 vacy and security;

1 “(C) health care providers;

2 “(D) health insurance plans or other third
3 party payors;

4 “(E) information technology vendors; and

5 “(F) purchasers or employers.

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

13 “(3) TERMS.—Members appointed under para-
14 graph (1) shall serve for 2 year terms, except that
15 any member appointed to fill a vacancy for an unex-
16 pired term shall be appointed for the remainder of
17 such term. A member may serve for not to exceed
18 180 days after the expiration of such member’s term
19 or until a successor has been appointed.

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

25 “(A) health information privacy;

1 “(B) health information security;

2 “(C) health care quality and patient safety,
3 including individuals with expertise in utilizing
4 health information technology to improve health
5 care quality and patient safety;

6 “(D) data exchange; and

7 “(E) developing health information tech-
8 nology standards and new health information
9 technology.

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

17 “(1) protection of individually identifiable
18 health information through privacy and security
19 practices;

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

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

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

6 “(5) fostering the public understanding of
7 health information technology;

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

10 “(7) recommendations for a nationwide inter-
11 operable health information technology infrastruc-
12 ture;

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

16 “(9) recommendations for the establishment of
17 an entity to ensure the continuation of the functions
18 of the Collaborative; and

19 “(10) other policies (including recommendations
20 for incorporating health information technology into
21 the provision of care and the organization of the
22 health care workplace) determined to be necessary
23 by the Collaborative.

24 “(d) STANDARDS.—

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

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

8 “(A) review existing standards (including
9 content, communication, and security stand-
10 ards) for the electronic exchange of health in-
11 formation;

12 “(B) identify deficiencies and omissions in
13 such existing standards; and

14 “(C) identify duplication and overlap in
15 such existing standards;

16 and recommend new standards and modifications to
17 such existing standards as necessary.

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

21 “(A) review existing standards (including
22 content, communication, and security stand-
23 ards) for the electronic exchange of health in-
24 formation;

1 “(B) identify deficiencies and omissions in
2 such existing standards; and

3 “(C) identify duplication and overlap in
4 such existing standards;
5 and recommend new standards and modifications to
6 such existing standards as necessary.

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

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

23 “(f) COORDINATION OF FEDERAL SPENDING.—

24 “(1) IN GENERAL.—Not later than 1 year after
25 the adoption by the Federal Government of a rec-

1 ommendation as provided for in subsection (e), and
2 in compliance with chapter 113 of title 40, United
3 States Code, no Federal agency shall expend Federal
4 funds for the purchase of any new health informa-
5 tion technology or health information technology sys-
6 tem for clinical care or for the electronic retrieval,
7 storage, or exchange of health information that is
8 not consistent with applicable standards adopted by
9 the Federal Government under subsection (e).

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

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

24 “(h) VOLUNTARY ADOPTION.—

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

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

10 “(3) LIMITATION.—Private entities that enter
11 into a contract with the Federal Government shall
12 adopt the standards adopted by the Federal Govern-
13 ment under this section for the purpose of activities
14 under such Federal contract.

15 “(i) REPORTS.—The Secretary shall submit to the
16 Committee on Health, Education, Labor, and Pensions
17 and the Committee on Finance of the Senate and the
18 Committee on Energy and Commerce and the Committee
19 on Ways and Means of the House of Representatives, on
20 an annual basis, a report that—

21 “(1) describes the specific actions that have
22 been taken by the Federal Government and private
23 entities to facilitate the adoption of an interoperable
24 nationwide system for the electronic exchange of
25 health information;

1 “(1) IN GENERAL.—The Secretary, based upon
2 the recommendations of the Collaborative, shall de-
3 velop criteria to ensure uniform and consistent im-
4 plementation of any standards for the electronic ex-
5 change of health information voluntarily adopted by
6 private entities in technical conformance with such
7 standards adopted under this title.

8 “(2) IMPLEMENTATION ASSISTANCE.—The Sec-
9 retary may recognize a private entity or entities to
10 assist private entities in the implementation of the
11 standards adopted under this title using the criteria
12 developed by the Secretary under this section.

13 “(b) CERTIFICATION.—

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

22 “(2) CERTIFICATION ASSISTANCE.—The Sec-
23 retary may recognize a private entity or entities to
24 assist in the certification described under paragraph

1 (1) using the criteria developed by the Secretary
2 under this section.

3 “(c) OUTSIDE INVOLVEMENT.—The Secretary,
4 through consultation with the Collaborative, may accept
5 recommendations on the development of the criteria under
6 subsections (a) and (b) from a Federal agency or private
7 entity.

8 **“SEC. 2905. GRANTS TO FACILITATE THE WIDESPREAD**
9 **ADOPTION OF INTEROPERABLE HEALTH IN-**
10 **FORMATION TECHNOLOGY.**

11 “(a) COMPETITIVE GRANTS TO FACILITATE THE
12 WIDESPREAD ADOPTION OF HEALTH INFORMATION
13 TECHNOLOGY.—

14 “(1) IN GENERAL.—The Secretary may award
15 competitive grants to eligible entities to facilitate the
16 purchase and enhance the utilization of qualified
17 health information technology systems to improve
18 the quality and efficiency of health care.

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

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

1 “(B) submit to the Secretary a strategic
2 plan for the implementation of data sharing
3 and interoperability measures;

4 “(C) be a—

5 “(i) not for profit hospital, including a
6 federally qualified health center (as defined
7 in section 1861(aa)(4) of the Social Secu-
8 rity Act);

9 “(ii) individual or group practice; or

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

12 “(D) adopt the standards adopted by the
13 Federal Government under section 2903;

14 “(E) implement the measures adopted
15 under section 2907 and report to the Secretary
16 on such measures;

17 “(F) agree to notify patients if their indi-
18 vidually identifiable health information is
19 wrongfully disclosed;

20 “(G) demonstrate significant financial
21 need; and

22 “(H) provide matching funds in accord-
23 ance with paragraph (4).

24 “(3) USE OF FUNDS.—Amounts received under
25 a grant under this subsection shall be used to facili-

1 tate the purchase and enhance the utilization of
2 qualified health information technology systems and
3 training personnel in the use of such technology.

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

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

13 “(A) eligible entities that are located in
14 rural, frontier, and other underserved areas as
15 determined by the Secretary;

16 “(B) eligible entities that will link, to the
17 extent practicable, the qualified health informa-
18 tion system to local or regional health informa-
19 tion plan or plans; and

20 “(C) with respect to an entity described in
21 subsection (a)(2)(C)(iii), a nonprofit health care
22 provider.

23 “(b) COMPETITIVE GRANTS TO STATES FOR THE DE-
24 VELOPMENT OF STATE LOAN PROGRAMS TO FACILITATE

1 THE WIDESPREAD ADOPTION OF HEALTH INFORMATION
2 TECHNOLOGY.—

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

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

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

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

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

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

6 “(D) require that health care providers re-
7 ceiving such loans—

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

12 “(ii) consult with the Health Informa-
13 tion Technology Resource Center estab-
14 lished in section 914(d) to access the
15 knowledge and experience of existing initia-
16 tives regarding the successful implementa-
17 tion and effective use of health information
18 technology; and

19 “(iii) agree to notify patients if their
20 individually identifiable health information
21 is wrongfully disclosed;

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

1 “(F) require that health care providers re-
2 ceiving such loans implement the measures
3 adopted under section 2907 and report to the
4 Secretary on such measures; and

5 “(G) provide matching funds in accordance
6 with paragraph (8).

7 “(4) STRATEGIC PLAN.—

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

13 “(B) CONTENTS.—A strategic plan under
14 subparagraph (A) shall include—

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

19 “(ii) a description of the criteria and
20 methods established for the distribution of
21 funds from the State loan fund; and

22 “(iii) a description of the financial
23 status of the State loan fund and the
24 short-term and long-term goals of the
25 State loan fund.

1 “(5) USE OF FUNDS.—

2 “(A) IN GENERAL.—Amounts deposited in
3 a State loan fund, including loan repayments
4 and interest earned on such amounts, shall be
5 used only for awarding loans or loan guaran-
6 tees, or as a source of reserve and security for
7 leveraged loans, the proceeds of which are de-
8 posited in the State loan fund established under
9 paragraph (1). Loans under this section may be
10 used by a health care provider to facilitate the
11 purchase and enhance the utilization of quali-
12 fied health information technology and training
13 of personnel in the use of such technology.

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

16 “(i) for the purchase or other acquisi-
17 tion of any health information technology
18 system that is not a qualified health infor-
19 mation technology system;

20 “(ii) to conduct activities for which
21 Federal funds are expended under this
22 title, or the amendments made by the
23 Wired for Health Care Quality Act; or

1 “(iii) for any purpose other than mak-
2 ing loans to eligible entities under this sec-
3 tion.

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

8 “(A) To award loans that comply with the
9 following:

10 “(i) The interest rate for each loan
11 shall be less than or equal to the market
12 interest rate.

13 “(ii) The principal and interest pay-
14 ments on each loan shall commence not
15 later than 1 year after the loan was award-
16 ed, and each loan shall be fully amortized
17 not later than 10 years after the date of
18 the loan.

19 “(iii) The State loan fund shall be
20 credited with all payments of principal and
21 interest on each loan awarded from the
22 fund.

23 “(B) To guarantee, or purchase insurance
24 for, a local obligation (all of the proceeds of
25 which finance a project eligible for assistance

1 under this subsection) if the guarantee or pur-
2 chase would improve credit market access or re-
3 duce the interest rate applicable to the obliga-
4 tion involved.

5 “(C) As a source of revenue or security for
6 the payment of principal and interest on rev-
7 enue or general obligation bonds issued by the
8 State if the proceeds of the sale of the bonds
9 will be deposited into the State loan fund.

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

12 “(7) ADMINISTRATION OF STATE LOAN
13 FUNDS.—

14 “(A) COMBINED FINANCIAL ADMINISTRA-
15 TION.—A State may (as a convenience and to
16 avoid unnecessary administrative costs) com-
17 bine, in accordance with State law, the financial
18 administration of a State loan fund established
19 under this subsection with the financial admin-
20 istration of any other revolving fund established
21 by the State if otherwise not prohibited by the
22 law under which the State loan fund was estab-
23 lished.

24 “(B) COST OF ADMINISTERING FUND.—
25 Each State may annually use not to exceed 4

1 percent of the funds provided to the State
2 under a grant under this subsection to pay the
3 reasonable costs of the administration of the
4 programs under this section, including the re-
5 covery of reasonable costs expended to establish
6 a State loan fund which are incurred after the
7 date of enactment of this title.

8 “(C) GUIDANCE AND REGULATIONS.—The
9 Secretary shall publish guidance and promul-
10 gate regulations as may be necessary to carry
11 out the provisions of this subsection, includ-
12 ing—

13 “(i) provisions to ensure that each
14 State commits and expends funds allotted
15 to the State under this subsection as effi-
16 ciently as possible in accordance with this
17 title and applicable State laws; and

18 “(ii) guidance to prevent waste, fraud,
19 and abuse.

20 “(D) PRIVATE SECTOR CONTRIBUTIONS.—

21 “(i) IN GENERAL.—A State loan fund
22 established under this subsection may ac-
23 cept contributions from private sector enti-
24 ties, except that such entities may not

1 specify the recipient or recipients of any
2 loan issued under this subsection.

3 “(ii) AVAILABILITY OF INFORMA-
4 TION.—A State shall make publicly avail-
5 able the identity of, and amount contrib-
6 uted by, any private sector entity under
7 clause (i) and may issue letters of com-
8 mendation or make other awards (that
9 have no financial value) to any such entity.

10 “(8) MATCHING REQUIREMENTS.—

11 “(A) IN GENERAL.—The Secretary may
12 not make a grant under paragraph (1) to a
13 State unless the State agrees to make available
14 (directly or through donations from public or
15 private entities) non-Federal contributions in
16 cash toward the costs of the State program to
17 be implemented under the grant in an amount
18 equal to not less than \$1 for each \$1 of Federal
19 funds provided under the grant.

20 “(B) DETERMINATION OF AMOUNT OF
21 NON-FEDERAL CONTRIBUTION.—In determining
22 the amount of non-Federal contributions that a
23 State has provided pursuant to subparagraph
24 (A), the Secretary may not include any

1 amounts provided to the State by the Federal
2 Government.

3 “(9) PREFERENCE IN AWARDING GRANTS.—
4 The Secretary may give a preference in awarding
5 grants under this subsection to States that adopt
6 value-based purchasing programs to improve health
7 care quality.

8 “(10) REPORTS.—The Secretary shall annually
9 submit to the Committee on Health, Education,
10 Labor, and Pensions and the Committee on Finance
11 of the Senate, and the Committee on Energy and
12 Commerce and the Committee on Ways and Means
13 of the House of Representatives, a report summa-
14 rizing the reports received by the Secretary from
15 each State that receives a grant under this sub-
16 section.

17 “(c) COMPETITIVE GRANTS FOR THE IMPLEMENTA-
18 TION OF REGIONAL OR LOCAL HEALTH INFORMATION
19 TECHNOLOGY PLANS.—

20 “(1) IN GENERAL.—The Secretary may award
21 competitive grants to eligible entities to implement
22 regional or local health information plans to improve
23 health care quality and efficiency through the elec-
24 tronic exchange of health information pursuant to
25 the standards, protocols, and other requirements

1 adopted by the Secretary under sections 2903 and
2 2907.

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

5 “(A) demonstrate financial need to the
6 Secretary;

7 “(B) demonstrate that one of its principal
8 missions or purposes is to use information tech-
9 nology to improve health care quality and effi-
10 ciency;

11 “(C) adopt bylaws, memoranda of under-
12 standing, or other charter documents that dem-
13 onstrate that the governance structure and de-
14 cisionmaking processes of such entity allow for
15 participation on an ongoing basis by multiple
16 stakeholders within a community, including—

17 “(i) physicians (as defined in section
18 1861(r) of the Social Security Act), includ-
19 ing physicians that provide services to low
20 income and underserved populations;

21 “(ii) hospitals (including hospitals
22 that provide services to low income and un-
23 derserved populations);

24 “(iii) pharmacists or pharmacies;

25 “(iv) health insurance plans;

1 “(v) health centers (as defined in sec-
2 tion 330(b)) and Federally qualified health
3 centers (as defined in section 1861(aa)(4)
4 of the Social Security Act);

5 “(vi) rural health clinics (as defined in
6 section 1861(aa) of the Social Security
7 Act);

8 “(vii) patient or consumer organiza-
9 tions;

10 “(viii) employers; and

11 “(ix) any other health care providers
12 or other entities, as determined appro-
13 priate by the Secretary;

14 “(D) demonstrate the participation, to the
15 extent practicable, of stakeholders in the elec-
16 tronic exchange of health information within
17 the local or regional plan pursuant to para-
18 graph (2)(C);

19 “(E) adopt nondiscrimination and conflict
20 of interest policies that demonstrate a commit-
21 ment to open, fair, and nondiscriminatory par-
22 ticipation in the health information plan by all
23 stakeholders;

24 “(F) adopt the standards adopted by the
25 Secretary under section 2903;

1 “(G) require that health care providers re-
2 ceiving such grants implement the measures
3 adopted under section 2907 and report to the
4 Secretary on such measures;

5 “(H) agree to notify patients if their indi-
6 vidually 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); and

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

16 “(3) APPLICATION.—

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

22 “(B) REQUIRED INFORMATION.—At a
23 minimum, an application submitted under this
24 paragraph shall include—

1 “(i) clearly identified short-term and
2 long-term objectives of the regional or local
3 health information plan;

4 “(ii) a technology plan that complies
5 with the standards adopted under section
6 2903 and that includes a descriptive and
7 reasoned estimate of costs of the hardware,
8 software, training, and consulting services
9 necessary to implement the regional or
10 local health information plan;

11 “(iii) a strategy that includes initia-
12 tives to improve health care quality and ef-
13 ficiency, including the use and reporting of
14 health care quality measures adopted
15 under section 2907;

16 “(iv) a plan that describes provisions
17 to encourage the implementation of the
18 electronic exchange of health information
19 by all physicians, including single physician
20 practices and small physician groups par-
21 ticipating in the health information plan;

22 “(v) a plan to ensure the privacy and
23 security of personal health information
24 that is consistent with Federal and State
25 law;

1 “(vi) a governance plan that defines
2 the manner in which the stakeholders shall
3 jointly make policy and operational deci-
4 sions on an ongoing basis;

5 “(vii) a financial or business plan that
6 describes—

7 “(I) the sustainability of the
8 plan;

9 “(II) the financial costs and ben-
10 efits of the plan; and

11 “(III) the entities to which such
12 costs and benefits will accrue; and

13 “(viii) in the case of an applicant enti-
14 ty that is unable to demonstrate the par-
15 ticipation of all stakeholders pursuant to
16 paragraph (2)(C), the justification from
17 the entity for any such nonparticipation.

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

22 “(5) MATCHING REQUIREMENT.—

23 “(A) IN GENERAL.—The Secretary may
24 not make a grant under this subsection to an
25 entity unless the entity agrees that, with re-

1 spect to the costs to be incurred by the entity
2 in carrying out the infrastructure program for
3 which the grant was awarded, the entity will
4 make available (directly or through donations
5 from public or private entities) non-Federal
6 contributions toward such costs in an amount
7 equal to not less than 50 percent of such costs
8 (\$1 for each \$2 of Federal funds provided
9 under the grant).

10 “(B) DETERMINATION OF AMOUNT CON-
11 TRIBUTED.—Non-Federal contributions re-
12 quired under subparagraph (A) may be in cash
13 or in kind, fairly evaluated, including equip-
14 ment, technology, or services. Amounts provided
15 by the Federal Government, or services assisted
16 or subsidized to any significant extent by the
17 Federal Government, may not be included in
18 determining the amount of such non-Federal
19 contributions.

20 “(d) REPORTS.—Not later than 1 year after the date
21 on which the first grant is awarded under this section,
22 and annually thereafter during the grant period, an entity
23 that receives a grant under this section shall submit to
24 the Secretary a report on the activities carried out under
25 the grant involved. Each such report shall include—

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

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

6 “(3) a description of any reduction in duplica-
7 tive or unnecessary care as a result of the project in-
8 volved;

9 “(4) a description of the efforts of recipients
10 under this section to facilitate secure patient access
11 to health information; and

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

14 “(e) REQUIREMENT TO ACHIEVE QUALITY IMPROVE-
15 MENT.—The Secretary shall annually evaluate the activi-
16 ties conducted under this section and shall, in awarding
17 grants, implement the lessons learned from such evalua-
18 tion in a manner so that awards made subsequent to each
19 such evaluation are made in a manner that, in the deter-
20 mination of the Secretary, will result in the greatest im-
21 provement in quality measures under section 2907.

22 “(f) LIMITATION.—An eligible entity may only receive
23 one non-renewable grant under subsection (a), one non-
24 renewable grant under subsection (b), and one non-renew-
25 able grant under subsection (c).

1 “(g) AUTHORIZATION OF APPROPRIATIONS.—

2 “(1) IN GENERAL.—For the purpose of car-
3 rying out this section, there is authorized to be ap-
4 propriated \$116,000,000 for fiscal year 2006,
5 \$141,000,000 for fiscal year 2007, and such sums
6 as may be necessary for each of fiscal years 2008
7 through 2010.

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

11 **“SEC. 2906. DEMONSTRATION PROGRAM TO INTEGRATE IN-**
12 **FORMATION TECHNOLOGY INTO CLINICAL**
13 **EDUCATION.**

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

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

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

1 “(2) submit to the Secretary a strategic plan
2 for integrating qualified health information tech-
3 nology in the clinical education of health profes-
4 sionals and for ensuring the consistent utilization of
5 decision support software to reduce medical errors
6 and enhance health care quality;

7 “(3) be—

8 “(A) a health professions school;

9 “(B) a school of nursing; or

10 “(C) an institution with a graduate med-
11 ical education program;

12 “(4) provide for the collection of data regarding
13 the effectiveness of the demonstration project to be
14 funded under the grant in improving the safety of
15 patients, the efficiency of health care delivery, and
16 in increasing the likelihood that graduates of the
17 grantee will adopt and incorporate health informa-
18 tion technology, and implement the quality measures
19 adopted under section 2907, in the delivery of health
20 care services; and

21 “(5) provide matching funds in accordance with
22 subsection (c).

23 “(c) USE OF FUNDS.—

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

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

3 “(B) use grant funds to integrate qualified
4 health information technology into community-
5 based clinical education.

6 “(2) LIMITATION.—An eligible entity shall not
7 use amounts received under a grant under sub-
8 section (a) to purchase hardware, software, or serv-
9 ices.

10 “(d) MATCHING FUNDS.—

11 “(1) IN GENERAL.—The Secretary may award
12 a grant to an entity under this section only if the
13 entity agrees to make available non-Federal con-
14 tributions toward the costs of the program to be
15 funded under the grant in an amount that is not
16 less than \$1 for each \$2 of Federal funds provided
17 under the grant.

18 “(2) DETERMINATION OF AMOUNT CONTRIB-
19 UTED.—Non-Federal contributions under paragraph
20 (1) may be in cash or in kind, fairly evaluated, in-
21 cluding equipment or services. Amounts provided by
22 the Federal Government, or services assisted or sub-
23 sidized to any significant extent by the Federal Gov-
24 ernment, may not be included in determining the
25 amount of such contributions.

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

6 “(f) REPORTS.—Not later than 1 year after the date
7 of enactment of this title, and annually thereafter, the Sec-
8 retary shall submit to the Committee on Health, Edu-
9 cation, Labor, and Pensions and the Committee on Fi-
10 nance of the Senate, and the Committee on Energy and
11 Commerce and the Committee on Ways and Means of the
12 House of Representatives a report that—

13 “(1) describes the specific projects established
14 under this section; and

15 “(2) contains recommendations for Congress
16 based on the evaluation conducted under subsection
17 (e).

18 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
19 is authorized to be appropriated to carry out this section,
20 \$5,000,000 for fiscal year 2007, and such sums as may
21 be necessary for each of fiscal years 2008 through 2010.

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

1 **“SEC. 2907. QUALITY MEASURES.**

2 “(a) IN GENERAL.—The Secretary shall develop
3 quality measures, including measures to assess the effec-
4 tiveness, timeliness, patient self-management, patient
5 centeredness, efficiency, and safety, for the purpose of
6 measuring the quality of care patients receive.

7 “(b) REQUIREMENTS.—The Secretary shall ensure
8 that the quality measures developed under this section
9 comply with the following:

10 “(1) MEASURES.—

11 “(A) REQUIREMENTS.—In developing the
12 quality measures under this section, the Sec-
13 retary shall, to the extent feasible, ensure
14 that—

15 “(i) such measures are evidence
16 based, reliable, and valid;

17 “(ii) such measures are consistent
18 with the purposes described in section
19 2902(b);

20 “(iii) such measures include measures
21 of clinical processes and outcomes, patient
22 experience, efficiency, and equity; and

23 “(iv) such measures include measures
24 of overuse and underuse of health care
25 items and services.

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

4 “(A) measures with the greatest potential
5 impact for improving the quality and efficiency
6 of care provided under this Act;

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

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

14 “(3) RISK ADJUSTMENT.—The Secretary shall
15 establish procedures to account for differences in pa-
16 tient health status, patient characteristics, and geo-
17 graphic location. To the extent practicable, such pro-
18 cedures shall recognize existing procedures.

19 “(4) MAINTENANCE.—The Secretary shall, as
20 determined appropriate, but in no case more often
21 than once during each 12-month period, update the
22 quality measures, including through the addition of
23 more accurate and precise measures and the retire-
24 ment of existing outdated measures.

1 “(5) RELATIONSHIP WITH PROGRAMS UNDER
2 THE SOCIAL SECURITY ACT.—The Secretary shall
3 ensure that the quality measures developed under
4 this section—

5 “(A) complement quality measures devel-
6 oped by the Secretary under programs adminis-
7 tered by the Secretary under the Social Security
8 Act, including programs under titles XVIII,
9 XIX, and XXI of such Act; and

10 “(B) do not conflict with the needs and
11 priorities of the programs under titles XVIII,
12 XIX, and XXI of such Act, as set forth by the
13 Administrator of the Centers for Medicare &
14 Medicaid Services.

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

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

22 “(2) any existing activities conducted by the
23 Secretary relating to measuring and rewarding qual-
24 ity and efficiency;

1 “(3) any existing activities conducted by private
2 entities, including health insurance plans and
3 payors;

4 “(4) the report by the Institute of Medicine of
5 the National Academy of Sciences under section
6 238(b) of the Medicare Prescription Drug, Improve-
7 ment, and Modernization Act of 2003; and

8 “(5) issues of data collection and reporting, in-
9 cluding the feasibility of collecting and reporting
10 data on measures.

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

16 “(1) Health insurance plans and health care
17 providers, including such plans and providers with
18 experience in the care of the frail elderly and indi-
19 viduals with multiple complex chronic conditions, or
20 groups representing such health insurance plans and
21 providers.

22 “(2) Groups representing patients and con-
23 sumers.

24 “(3) Purchasers and employers or groups rep-
25 resenting purchasers or employers.

1 “(4) Organizations that focus on quality im-
2 provement as well as the measurement and reporting
3 of quality measures.

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

6 “(6) State government public health programs.

7 “(7) Individuals or entities skilled in the con-
8 duct and interpretation of biomedical, health serv-
9 ices, and health economics research and with exper-
10 tise in outcomes and effectiveness research and tech-
11 nology assessment.

12 “(8) Individuals or entities involved in the de-
13 velopment and establishment of standards and cer-
14 tification for health information technology systems
15 and clinical data.

16 “(9) Individuals or entities with experience
17 with—

18 “(A) urban health care issues;

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

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

21 “(e) USE OF QUALITY MEASURES.—

22 “(1) IN GENERAL.—For purposes of activities
23 conducted or supported by the Secretary under this
24 Act, the Secretary shall, to the extent practicable,

1 adopt and utilize the quality measures developed
2 under this section.

3 “(2) COLLABORATIVE AGREEMENTS.—With re-
4 spect to activities conducted or supported by the
5 Secretary under this Act, the Secretary may estab-
6 lish collaborative agreements with private entities,
7 including group health plans and health insurance
8 issuers, providers, purchasers, consumer organiza-
9 tions, and entities receiving a grant under section
10 2905, to—

11 “(A) encourage the use of the quality
12 measures adopted by the Secretary under this
13 section; and

14 “(B) foster uniformity between the health
15 care quality measures utilized by private enti-
16 ties.

17 “(3) REPORTING.—The Secretary shall imple-
18 ment procedures to enable the Department of
19 Health and Human Services to accept the electronic
20 submission of data for purposes of—

21 “(A) quality measurement using the qual-
22 ity measures developed under this section and
23 using the standards adopted by the Federal
24 Government under section 2903; and

1 “(B) for reporting measures used to make
2 value-based payments under programs under
3 the Social Security Act.

4 “(f) DISSEMINATION OF INFORMATION.—Beginning
5 on January 1, 2008, in order to make comparative quality
6 information available to health care consumers, health
7 professionals, public health officials, researchers, and
8 other appropriate individuals and entities, the Secretary
9 shall provide for the dissemination, aggregation, and anal-
10 ysis of quality measures collected under section 2905 and
11 the dissemination of recommendations and best practices
12 derived in part from such analysis.

13 “(g) TECHNICAL ASSISTANCE.—The Secretary shall
14 provide technical assistance to public and private entities
15 to enable such entities to—

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

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

23 “(h) RULE OF CONSTRUCTION.—Nothing in this title
24 shall be construed as prohibiting the Secretary, acting
25 through the Administrator of the Centers for Medicare &

1 Medicaid Services, from developing quality measures (and
2 timing requirements for reporting such measures) for use
3 under programs administered by the Secretary under the
4 Social Security Act, including programs under titles
5 XVIII, XIX, and XXI of such Act.”.

6 **SEC. 3. LICENSURE AND THE ELECTRONIC EXCHANGE OF**
7 **HEALTH INFORMATION.**

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

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

14 (2) how such variation among State laws im-
15 pacts the secure electronic exchange of health infor-
16 mation—

17 (A) among the States; and

18 (B) between the States and the Federal
19 Government.

20 (b) REPORT AND RECOMMENDATIONS.—Not later
21 than 1 year after the date of enactment of this Act, the
22 Secretary of Health and Human Services shall publish a
23 report that—

24 (1) describes the results of the study carried
25 out under subsection (a); and

1 (2) makes recommendations to States regarding
2 the harmonization of State laws based on the results
3 of such study.

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

5 Nothing in this Act (or the amendments made by this
6 Act) shall be construed to affect the scope, substance, or
7 applicability of—

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

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

12 (3) any regulation issued pursuant to any such
13 section.

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

15 Not later than 6 months after the date of enactment
16 of this Act, the Comptroller General of the United States
17 shall submit to Congress a report on the necessity and
18 workability of requiring health plans (as defined in section
19 1171 of the Social Security Act (42 U.S.C. 1320d)),
20 health care clearinghouses (as defined in such section
21 1171), and health care providers (as defined in such sec-
22 tion 1171) who transmit health information in electronic
23 form, to notify patients if their individually identifiable
24 health information (as defined in such section 1171) is
25 wrongfully disclosed.

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

2 The Secretary of Health and Human Services shall
3 carry out, or contract with a private entity to carry out,
4 a study that examines methods to create efficient reim-
5 bursement incentives for improving health care quality in
6 Federally qualified health centers, rural health clinics, and
7 free clinics.

8 **SEC. 7. HEALTH INFORMATION TECHNOLOGY RESOURCE**
9 **CENTER.**

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

13 “(d) HEALTH INFORMATION TECHNOLOGY RE-
14 SOURCE CENTER.—

15 “(1) IN GENERAL.—The Secretary, acting
16 through the Director, shall develop a Health Infor-
17 mation Technology Resource Center to provide tech-
18 nical assistance and develop best practices to sup-
19 port and accelerate efforts to adopt, implement, and
20 effectively use interoperable health information tech-
21 nology in compliance with section 2903 and 2907.

22 “(2) PURPOSES.—The purpose of the Center is
23 to—

24 “(A) provide a forum for the exchange of
25 knowledge and experience;

1 “(B) accelerate the transfer of lessons
2 learned from existing public and private sector
3 initiatives, including those currently receiving
4 Federal financial support;

5 “(C) assemble, analyze, and widely dis-
6 seminate evidence and experience related to the
7 adoption, implementation, and effective use of
8 interoperable health information technology.

9 “(D) provide for the establishment of re-
10 gional and local health information networks to
11 facilitate the development of interoperability
12 across health care settings and improve the
13 quality of health care;

14 “(E) provide for the development of solu-
15 tions to barriers to the exchange of electronic
16 health information; and

17 “(F) conduct other activities identified by
18 the States, local or regional health information
19 networks, or health care stakeholders as a focus
20 for developing and sharing best practices.

21 “(3) SUPPORT FOR ACTIVITIES.—To provide
22 support for the activities of the Center, the Director
23 shall modify the requirements, if necessary, that
24 apply to the National Resource Center for Health
25 Information Technology to provide the necessary in-

1 frastructure to support the duties and activities of
2 the Center and facilitate information exchange
3 across the public and private sectors.

4 “(4) RULE OF CONSTRUCTION.—Nothing in
5 this subsection shall be construed to require the du-
6 plication of Federal efforts with respect to the estab-
7 lishment of the Center, regardless of whether such
8 efforts were carried out prior to or after the enact-
9 ment of this subsection.

10 “(e) TECHNICAL ASSISTANCE TELEPHONE NUMBER
11 OR WEBSITE.—The Secretary shall establish a toll-free
12 telephone number or Internet website to provide health
13 care providers and patients with a single point of contact
14 to—

15 “(1) learn about Federal grants and technical
16 assistance services related to interoperable health in-
17 formation technology;

18 “(2) learn about qualified health information
19 technology and the quality measures adopted by the
20 Federal Government under sections 2903 and 2907;

21 “(3) learn about regional and local health infor-
22 mation networks for assistance with health informa-
23 tion technology; and

24 “(4) disseminate additional information deter-
25 mined by the Secretary.

