To reduce healthcare costs, improve efficiency, and improve healthcare quality through the development of a nationwide interoperable health information technology system, and for other purposes.

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

3 SECTION 1. SHORT TITLE.

This Act may be cited as the “Health Technology to Enhance Quality Act of 2005” or the “Health TEQ Act of 2005”.
TITLE I—HEALTH INFORMATION TECHNOLOGY STANDARDS
ADOPTION AND INFRASTRUCTURE DEVELOPMENT

SEC. 101. ESTABLISHMENT OF NATIONAL COORDINATOR;
RECOMMENDATION, ADOPTION, AND IMPLEMENTATION OF HEALTH INFORMATION ELECTRONIC EXCHANGE STANDARDS.

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

“TITLE XXIX—HEALTH INFORMATION TECHNOLOGY

“SEC. 2901. DEFINITIONS.

“For purposes of this title:

“(1) GROUP HEALTH PLAN.—The term ‘group health plan’ has the meaning giving that term in section 2791.

“(2) HEALTHCARE PROVIDER.—The term ‘healthcare provider’ means a hospital, skilled nursing facility, home health entity, healthcare clinic, community health center, group practice (as defined in section 1877(h)(4) of the Social Security Act), a physician (as defined in section 1861(r)(1) of the Social Security Act), a pharmacist, a pharmacy, a
laboratory, and any other category of facility or clinician determined appropriate by the Secretary.

“(3) HEALTH INFORMATION.—The term ‘health information’ means any information, recorded in any form or medium, that relates to the past, present, or future physical or mental health or condition of an individual, the provision of healthcare to an individual, or the past, present, or future payment for the provision of healthcare to an individual.

“(4) HEALTH INSURANCE ISSUER.—The term ‘health insurance issuer’ has the meaning given that term in section 2791.

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

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

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

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

“(b) PURPOSE.—It shall be the purpose of the Office
to carry out programs and activities to develop a nation-
wide interoperable health information technology infra-
structure that—

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

“(2) reduces healthcare costs resulting from in-
efficiency, medical errors, inappropriate care, and in-
complete information;

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

“(4) promotes a more effective marketplace,
greater competition, and increased choice through
the wider availability of accurate information on
healthcare costs, quality, and outcomes;

“(5) improves the coordination of care and in-
formation among hospitals, laboratories, physician
offices, and other entities through an effective infra-
structure for the secure and authorized exchange of
healthcare information;
“(6) improves public health reporting and facilitates the early identification and rapid response to public health threats and emergencies, including bioterror events and infectious disease outbreaks;

“(7) facilitates health research; and

“(8) ensures that patients’ health information is secure and protected.

“(c) DUTIES OF NATIONAL COORDINATOR.—

“(1) IN GENERAL.—The National Coordinator shall—

“(A) facilitate the adoption of a national system for the electronic exchange of health information;

“(B) serve as the principal advisor to the Secretary on the development, application, and use of health information technology, and coordinate and oversee the health information technology programs of the Department;

“(C) ensure the adoption and implementation of standards for the electronic exchange of health information, including coordinating the activities of the Standards Working Group under section 2903;
“(D) carry out activities related to the electronic exchange of health information that reduce cost and improve healthcare quality;

“(E) ensure that health information technology policy and programs of the Department are coordinated with those of relevant executive branch agencies (including Federal commissions) with a goal of avoiding duplication of efforts and of helping to ensure that each agency undertakes health information technology activities primarily within the areas of its greatest expertise and technical capability;

“(F) to the extent permitted by law, coordinate outreach and consultation by the relevant executive branch agencies (including Federal commissions) with public and private parties of interest, including consumers, payers, employers, hospitals and other healthcare providers, physicians, community health centers, laboratories, vendors and other stakeholders;

“(G) advise the President regarding specific Federal health information technology programs; and

“(H) submit the reports described under paragraph (2).
“(2) REPORTS TO CONGRESS.—The National Coordinator shall submit to Congress, on an annual basis, a report that describes—

“(A) specific steps that have been taken to facilitate the adoption of a nationwide system for the electronic exchange of health information;

“(B) barriers to the adoption of such a nationwide system; and

“(C) recommendations to achieve full implementation of such a nationwide system.

“(d) DETAIL OF FEDERAL EMPLOYEES.—

“(1) IN GENERAL.—Upon the request of the National Coordinator, the head of any Federal agency is authorized to detail, with or without reimbursement from the Office, any of the personnel of such agency to the Office to assist it in carrying out its duties under this section.

“(2) EFFECT OF DETAIL.—Any such detail shall—

“(A) not interrupt or otherwise affect the civil service status or privileges of the Federal employee; and
“(B) be in addition to any other staff of the Department employed by the National Coordinator.

“(3) ACCEPTANCE OF DETAILEES.—Notwithstanding any other provision of law, the Office may accept detailed personnel from other Federal agencies without regard to whether the agency described under paragraph (1) is reimbursed.

“(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the activities of the Office under this section for each of fiscal years 2006 through 2010.

“SEC. 2903. COLLABORATIVE PROCESS FOR THE RECOMMENDATION, ADOPTION, AND IMPLEMENTATION OF HEALTH INFORMATION STANDARDS.

“(a) ESTABLISHMENT OF WORKING GROUP.—Not later than 60 days after the date of enactment of this title, the National Coordinator, in consultation with the Director of the National Institute of Standards and Technology (referred to in this section as the ‘Director’), shall establish a permanent Electronic Health Information Standards Development Working Group (referred to in this title as the ‘Standards Working Group’).
“(b) COMPOSITION.—The Standards Working Group shall be composed of—

“(1) the National Coordinator, who shall serve as the chairperson of the Standards Working Group;

“(2) the Director;

“(3) representatives of the relevant Federal agencies and departments, as selected by the Secretary in consultation with the National Coordinator, including representatives of the Department of Veterans Affairs, the Department of Defense, the Office of Management and Budget, the Department of Homeland Security, and the Environmental Protection Agency;

“(4) private entities accredited by the American National Standards Institute, as selected by the National Coordinator;

“(5) representatives, as selected by the National Coordinator—

“(A) of group health plans or other health insurance issuers;

“(B) of healthcare provider organizations;

“(C) with expertise in health information security;

“(D) with expertise in health information privacy;
“(E) with experience in healthcare quality and patient safety, including those with experience in utilizing health information technology to improve healthcare quality and patient safety;

“(F) of consumer and patient organizations;

“(G) of employers;

“(H) with experience in data exchange; and

“(I) with experience in developing health information technology standards and new health information technology; and

“(6) other representatives as determined appropriate by the National Coordinator in consultation with the Secretary.

“(c) STANDARDS DEEMED ADOPTED.—On the date of enactment of this title, the Secretary and the Standards Working Group shall deem as adopted, for use by the Secretary and private entities, the standards adopted by the Consolidated Health Informatics Initiative prior to such date of enactment.

“(d) DUTIES.—
“(1) **First Year Review.**—Not later than 1 year after the date of enactment of this title, the Standards Working Group shall—

“(A) review existing standards (including content, communication, and security standards) for the electronic exchange of health information, including such standards deemed adopted under subsection (c);

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

“(C) identity duplications and omissions in existing standards, and recommend modifications to such standards as necessary; and

“(D) submit a report to the Secretary recommending for adoption by such Secretary and private entities—

“(i) modifications to the standards deemed adopted under subsection (c); and

“(ii) any additional standards reviewed pursuant to this paragraph.

“(2) **Ongoing Review.**—Beginning 1 year after the date of enactment of this title, and on an ongoing basis thereafter, the Standards Working Group shall—
“(A) review existing standards (including content, communication, and security standards) for the electronic exchange of health information, including such standards adopted by the Secretary under subsections (c) and (e);

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

“(C) identity duplications and omissions in existing standards, and recommend modifications to such standards as necessary; and

“(D) submit reports to the Secretary recommending for adoption by such Secretary and private entities—

“(i) modifications to any existing standards; and

“(ii) any additional standards reviewed pursuant to this paragraph.

“(3) LIMITATION.—The standards described under this subsection shall not include any standards developed pursuant the Health Insurance Portability and Accountability Act of 1996.

“(e) ADOPTION BY SECRETARY.—Not later than 1 year after the receipt of a report from the Standards Working Group under paragraph (1)(D) or (2)(D) of subsection (d), the Secretary shall review and provide for the
adoption by the Federal Government of any modification
or standard recommended in such report.

“(f) VOLUNTARY ADOPTION.—Any standards adopt-
ed by the Secretary under this section shall be voluntary
for private entities.

“(g) APPLICATION OF FACA.—

“(1) IN GENERAL.—The Federal Advisory Com-
mittee Act (5 U.S.C. App.) shall apply to the Stand-
ards Working Group established under this section.

“(2) LIMITATION.—Notwithstanding paragraph
(1), the 2-year termination date under section 14 of
the Federal Advisory Committee Act shall not apply
to the Standards Working Group.

“SEC. 2904. IMPLEMENTATION AND CERTIFICATION OF
HEALTH INFORMATION STANDARDS.

“(a) IMPLEMENTATION.—

“(1) IN GENERAL.—The Secretary, in consulta-
tion with the National Coordinator and the Director
of the National Institute of Standards and Tech-
nology, shall develop criteria to ensure uniform and
consistent implementation of any standards for the
electronic exchange of health information voluntarily
adopted by private entities in technical conformance
with such standards adopted under this title.
“(2) IMPLEMENTATION ASSISTANCE.—The Secretary may recognize a private entity or entities to assist private entities in the implementation of the standards adopted under this title.

“(b) CERTIFICATION.—

“(1) IN GENERAL.—The Secretary, in consultation with the National Coordinator and the Director of the National Institute of Standards and Technology shall develop criteria to ensure and certify that hardware, software, and support services that claim to be in compliance with any standard for the electronic exchange of health information adopted under this title have established and maintain such compliance in technical conformance with such standard.

“(2) CERTIFICATION ASSISTANCE.—The Secretary may recognize a private entity or entities to assist in the certification described under paragraph (1).

“(c) DELEGATION AUTHORITY.—The Secretary may delegate the development of the criteria under subsection (a) and (b) to a private entity.
“SEC. 2905. AUTHORITY FOR COORDINATION AND SPENDING.

“(a) IN GENERAL.—The Secretary acting through the National Coordinator—

“(1) shall direct and coordinate—

“(A) Federal spending related to the development, adoption, and implementation of standards for the electronic exchange of health information; and

“(B) the adoption of the recommendations submitted to such Secretary by the Standards Working Group established under section 2903; and

“(2) may utilize the entities recognized under section 2904 to assist in implementation and certification related to the implementation by the Federal Government of the standards adopted by the Secretary under this title.

“(b) LIMITATION.—

“(1) IN GENERAL.—Notwithstanding any other provision of law, no Federal agency shall expend Federal funds for the purchase of hardware, software, or support services for the purpose of implementing a standard related to the electronic exchange of health information that is not a standard adopted by the Secretary under section 2903.
“(2) **Effective Date.**—The limitation under paragraph (1) shall take effect not later than 1 year after the adoption by the Secretary of such standards under section 2903.”

**SEC. 102. ENCOURAGING SECURE EXCHANGE OF HEALTH INFORMATION.**

(a) **Study and Grant Programs Related to State Health Information Laws and Practices.**—

(1) **Study of State Health Information Laws and Practices.**—

(A) **In General.**—The Secretary of Health and Human Services (referred to in this Act as the “Secretary”) shall carry out, or contract with a private entity to carry out, a study that examines—

(i) the variation among State laws and practices that relate to the privacy, confidentiality, and security of health information;

(ii) how such variation among State laws and practices may impact the electronic exchange of health information (as defined in section 2901 of the Public Health Service Act) (as added by section 101)—
(I) among the States;

(II) between the States and the Federal Government; and

(III) among private entities; and

(iii) how such laws and practices may be harmonized to permit the secure electronic exchange of health information.

(B) REPORT AND RECOMMENDATIONS.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to Congress a report that—

(i) describes the results of the study carried out under subparagraph (A); and

(ii) makes recommendations based on the results of such study.

(2) SECURE EXCHANGE OF HEALTH INFORMATION; INCENTIVE GRANTS.—Title XXIX of the Public Health Service Act (as added by section 101) is amended by adding at the end the following:

“SEC. 2906. SECURE EXCHANGE OF HEALTH INFORMATION; INCENTIVE GRANTS.

“(a) IN GENERAL.—The Secretary may make grants to States to carry out programs under which such States cooperate with other States to develop and implement State policies that will facilitate the secure electronic ex-
change of health information utilizing the standards
adopted under section 2903—
“(1) among the States;
“(2) between the States and the Federal Gov-
ernment; and
“(3) among private entities.
“(b) PRIORITY.—In awarding grants under sub-
section (a), the Secretary shall give priority to States that
provide assurance that any funding awarded under such
a grant shall be used to harmonize privacy laws and prac-
tices between the States, the States and the Federal Gov-
ernment, and among private entities related to the privacy,
confidentiality, and security of health information.
“(c) DISSEMINATION OF INFORMATION.—The Sec-
retary shall disseminate information regarding the efficacy
of efforts of a recipient of a grant under this section.
“(d) TECHNICAL ASSISTANCE.—The Secretary may
provide technical assistance to recipients of a grant under
this section.
“(e) AUTHORIZATION OF APPROPRIATIONS.—For the
purpose of carrying out subsection (a), there are author-
ized to be appropriated such sums as may be necessary
for each of the fiscal years 2006 through 2010.”.
(b) STUDY AND GRANT PROGRAMS RELATED TO
STATE LICENSURE LAWS.—
(1) **Study of State Licensure Laws.**—

(A) **In General.**—The Secretary shall carry out, or contract with a private entity to carry out, a study that examines—

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

(ii) how such variation among State laws impacts the secure electronic exchange of health information (as defined in section 2901 of the Public Health Service Act) (as added by section 101)—

(I) among the States; and

(II) between the States and the Federal Government.

(B) **Report and Recommendations.**—Not later than 1 year after the date of enactment of this Act, the Secretary shall publish a report that—

(i) describes the results of the study carried out under subparagraph (A); and

(ii) makes recommendations to States regarding the harmonization of State laws based on the results of such study.
(2) **Reauthorization of incentive grants regarding telemedicine.**—Section 330L(b) of the Public Health Service Act (42 U.S.C. 254c-18(b)) is amended by striking “2002 through 2006” and inserting “2006 through 2010”.

(3) **HIPAA application to electronic health information.**—Title XXIX of the Public Health Service Act (as added by section 101 and amended by subsection (a)) is further amended by adding at the end the following:

‘‘SEC. 2907. APPLICABILITY OF PRIVACY AND SECURITY REGULATIONS.

‘‘The regulations promulgated by the Secretary under part C of title XI of the Social Security Act and sections 261, 262, 263, and 264 of the Health Insurance Portability and Accountability Act of 1996 with respect to the privacy, confidentiality, and security of health information shall—

‘‘(1) apply to any health information stored or transmitted in an electronic format as of the date of enactment of this title; and

‘‘(2) apply to the implementation of standards, programs, and activities under this title.’’.

(c) **Study and report.**—
(1) STUDY.—Not later than 2 years after the date of enactment of this Act, the Secretary shall carry out, or contract with a private entity to carry out, a study that examines the integration of the standards adopted under the amendments made by this Act with the standards adopted under the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

(2) PLAN; REPORT.—

(A) PLAN.—Not later than 3 years after the date of enactment of this Act, the Secretary shall, based on the results of the study carried out under paragraph (1), develop a plan for the integration of the standards described under such paragraph and submit a report to Congress describing such plan.

(B) PERIODIC REPORTS.—The Secretary shall submit periodic reports to Congress that describe the progress of the integration described under subparagraph (A).
TITLE II—FACILITATING THE
ADOPTION AND IMPLEMENTATION OF INTEROPERABLE
ELECTRONIC HEALTH INFORMATION

SEC. 201. GRANTS FOR THE IMPLEMENTATION OF REGIONAL OR LOCAL HEALTH INFORMATION TECHNOLOGY PLANS.

Title XXIX of the Public Health Service Act (as amended by section 102) is further amended by adding at the end the following:

“SEC. 2908. GRANTS FOR THE IMPLEMENTATION OF REGIONAL OR LOCAL HEALTH INFORMATION TECHNOLOGY PLANS.

“(a) IN GENERAL.—The Secretary, in consultation with the National Coordinator, may award competitive grants to eligible entities to implement regional or local health information plans to improve healthcare quality and efficiency through the electronic exchange of health information pursuant to the standards, protocols, and other requirements adopted by the Secretary under sections 2903 and 2910.

“(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a) an entity shall—
“(1) demonstrate financial need to the Secretary;

“(2) demonstrate that one of its principal missions or purposes is to use information technology to improve healthcare quality and efficiency;

“(3) adopt bylaws, memoranda of understanding, or other charter documents that demonstrate that the governance structure and decision-making processes of such entity allow for participation on an ongoing basis by multiple stakeholders within a community, including—

“(A) physicians (as defined in section 1861(r)(1) of the Social Security Act), including physicians that provide services to low income and underserved populations;

“(B) hospitals (including hospitals that provide services to low income and underserved populations);

“(C) group health plans or other health insurance issuers;

“(D) health centers (as defined in section 330(b)) and Federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act);
“(E) rural health clinics (as defined in section 1861(aa) of the Social Security Act);

“(F) consumer organizations;

“(G) employers; and

“(H) any other healthcare providers or other entities, as determined appropriate by the Secretary;

“(4) adopt nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory participation in the health information plan by all stakeholders;

“(5) adopt the national health information technology standards adopted by the Secretary under section 2903;

“(6) facilitate the electronic exchange of health information within the local or regional area and among local and regional areas;

“(7) prepare and submit to the Secretary an application in accordance with subsection (c); and

“(8) agree to provide matching funds in accordance with subsection (e).

“(c) APPLICATION.—

“(1) IN GENERAL.—To be eligible to receive a grant under subsection (a), an entity shall submit to the Secretary an application at such time, in such
manner, and containing such information as the Secretary may require.

“(2) REQUIRED INFORMATION.—At a minimum, an application submitted under this subsection shall include—

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

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

“(C) a strategy that includes initiatives to improve healthcare quality and efficiency, including the use of healthcare quality measures adopted under section 2910;

“(D) a plan that describes provisions to encourage the implementation of the electronic exchange of health information by all physicians, including single physician practices and small physician groups participating in the health information plan;
'(E) a plan to ensure the privacy and security of personal health information that is consistent with Federal and State law;

(F) a governance plan that defines the manner in which the stakeholders shall jointly make policy and operational decisions on an ongoing basis; and

(G) a financial or business plan that describes—

(i) the sustainability of the plan;

(ii) the financial costs and benefits of the plan; and

(iii) the entities to which such costs and benefits will accrue.

(d) USE OF FUNDS.—Amounts received under a grant under subsection (a) shall be used to establish and implement a regional or local health information plan in accordance with this section.

(e) MATCHING REQUIREMENT.—

(1) IN GENERAL.—The Secretary may not make a grant under this section to an entity unless the entity agrees that, with respect to the costs to be incurred by the entity in carrying out the infrastructure program for which the grant was awarded, the entity will make available (directly or through
donations from public or private entities) non-Federal contributions toward such costs in an amount equal to not less than 50 percent of such costs ($1 for each $2 of Federal funds provided under the grant).

“(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions required under paragraph (1) may be in cash or in kind, fairly evaluated, including equipment, technology, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

“(f) AUTHORIZATION OF APPROPRIATIONS.—

“(1) IN GENERAL.—There is authorized to be appropriated to carry out this section, $125,000,000 for each of fiscal years 2006 through 2010.

“(2) AVAILABILITY.—Amounts appropriated under paragraph (1) shall remain available for obligation until expended.

“SEC. 2909. REPORTS.

“Not later than 1 year after the date on which the first grant is awarded under section 2908, and annually thereafter during the grant period, an entity that receives
a grant under such section shall submit to the Secretary, acting through the National Coordinator, a report on the activities carried out under the grant involved. Each such report shall include—

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

“(2) an analysis of the impact of the project on healthcare quality and safety;

“(3) a description of any reduction in duplicative or unnecessary care as a result of the project involved; and

“(4) other information as required by the Secretary.”.

SEC. 202. EXCEPTION FOR THE PROVISION OF PERMITTED SUPPORT.

(a) EXEMPTION FROM CRIMINAL PENALTIES.—Section 1128B(b) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)) is amended—

(1) in paragraph (3)—

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

(B) in subparagraph (H), as added by section 237(d) of the Medicare Prescription Drug,
Improvement, and Modernization Act of 2003
(Public Law 108–173; 117 Stat. 2213)—

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

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

(C) by redesignating subparagraph (H), as
added by section 431(a) of the Medicare Pre-
scription Drug, Improvement, and Moderniza-
tion Act of 2003 (Public Law 108–173; 117
Stat. 2287), as subparagraph (I);

(D) in subparagraph (I), as so
redesignated—

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

(ii) by striking the period at the end
and inserting “; and”;

(E) by adding at the end the following
new:

“(J) subject to paragraph (4), the provi-
sion, with or without charge, of any permitted
support (as defined in paragraph (4)(A) and
subject to the conditions in paragraph (4)(B))
to an entity or individual for developing, imple-
menting, operating, or facilitating the electronic
exchange of health information (as defined in section 2901 of the Public Health Service Act), so long as such support is primarily designed to promote the electronic exchange of health information.”; and

(2) by adding at the end the following:

“(4) PERMITTED SUPPORT.—

“(A) DEFINITION OF PERMITTED SUPPORT.—In this section, the term ‘permitted support’ means the provision of, or funding used exclusively to provide or pay for, any equipment, item, information, right, license, intellectual property, software, or service, regardless of whether any such support may have utility or value to the recipient for any purpose beyond the exchange of health information (as defined in section 2901 of the Public Health Service Act).

“(B) CONDITIONS ON PERMITTED SUPPORT.—Paragraph (3)(J) shall not apply unless the following conditions are met:

“(i) The provision of permitted support is not conditioned on the recipient of such support making any referral to, or generating any business for, any entity or
individual for which any Federal health care program provides reimbursement.

“(ii) The permitted support complies with the standards for the electronic exchange of health information adopted by the Secretary under section 2903 of the Public Health Service Act.

“(iii) The entity or network receiving permitted support is able to document that such support is used by the entity or the network for the electronic exchange of health information in accordance with the standards adopted by the Secretary under section 2903 of the Public Health Service Act.”.

(b) EXEMPTION FROM LIMITATION ON CERTAIN PHYSICIAN REFERRALS.—Section 1877(e) of the Social Security Act (42 U.S.C. 1395nn(e)) is amended by adding at the end the following:

“(9) PERMITTED SUPPORT.—The provision of permitted support (as described in section 1128B(b)(3)(J)).”.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to permitted support provided on or after the date of enactment of this Act.
SEC. 203. GROUP PURCHASING.

(a) In General.—Not later than 1 year after the date of enactment of this Act, the Secretary shall establish a safe harbor for group purchasing of hardware, software, and support services for the electronic exchange of health information in compliance with section 2903 of the Public Health Service Act (as added by section 101).

(b) Conditions.—In establishing the safe harbor under subsection (a), the Secretary shall establish conditions on such safe harbor consistent with the purposes of—

(1) improving healthcare quality;

(2) reducing medical errors;

(3) reducing healthcare costs;

(4) improving the coordination of care;

(5) streamlining administrative processes; and

(6) promoting transparency and competition.

SEC. 204. PERMISSIBLE ARRANGEMENTS.

(a) In General.—Not later than 1 year after the date of enactment of this Act and notwithstanding any other provision of law, the Secretary shall establish guidelines in compliance with section 2903 of the Public Health Service Act that permit certain arrangements between group health plans and health insurance issuers (as defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91)) and between healthcare providers (as
defined in section 2901 of such Act, as added by section 101) in accordance with subsection (b).

(b) CONDITIONS.—In establishing the guidelines under subsection (a), the Secretary shall establish conditions on such arrangements consistent with the purposes of—

(1) improving healthcare quality;
(2) reducing medical errors;
(3) reducing healthcare costs;
(4) improving the coordination of care;
(5) streamlining administrative processes; and
(6) promoting transparency and competition.

TITLE III—ADOPTION, IMPLEMENTATION, AND USE OF HEALTHCARE QUALITY MEASURES

SEC. 301. STANDARDIZED MEASURES.

Title XXIX of the Public Health Service Act (as amended by section 201) is further amended by adding at the end the following:

“SEC. 2910. COLLABORATIVE PROCESS FOR THE DEVELOPMENT, RECOMMENDATION, AND ADOPTION OF STANDARDIZED MEASURES OF QUALITY HEALTHCARE.

“(a) IN GENERAL.—
“(1) Collaboration.—The Secretary, the Secretary of Defense, the Secretary of Veterans Affairs, and any other heads of relevant Federal agencies as determined appropriate by the President, referred to in this section as the ‘Secretaries’) shall adopt, on an ongoing basis, uniform healthcare quality measures to assess the effectiveness, timeliness, patient self-management, patient-centeredness, efficiency, and safety of care delivered by healthcare providers across Federal healthcare programs, including those in titles XVIII, XIX, and XXI of the Social Security Act.

“(2) Review of measures adopted.—The Secretaries shall conduct an ongoing review of the measures adopted under paragraph (1).

“(3) Existing activities.—Notwithstanding any other provision of law, the measures and reporting activities described in this subsection shall replace, to the extent practicable and appropriate, any duplicative or redundant existing measurement and reporting activities currently utilized by Federal healthcare programs, including those in titles XVIII, XIX, and XXI of the Social Security Act.

“(b) Priority Measures.—
“(1) IN GENERAL.—In determining the measures to be adopted under subsection (a), and the timing of any such adoption, the Secretaries shall give priority to—

“(A) measures with the greatest potential impact for improving the quality and efficiency of care provided under Federal programs;

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

“(C) measures which may inform healthcare decisions made by consumers and patients.

“(2) NATIONAL QUALITY FORUM MEASURES; QUALITY OF CARE INDICATORS.—To the extent determined feasible and appropriate by the Secretaries, the Secretaries shall adopt—

“(A) measures endorsed by the National Quality Forum, subject to compliance with the amendments made by the National Technology Transfer and Advancement Act of 1995; and

“(B) indicators relating to the quality of care data submitted to the Secretary by hos-
pitals under section 1886(b)(3)(B)(vii)(II) of the Social Security Act.

“(c) COLLABORATION WITH PRIVATE ENTITIES.—

“(1) IN GENERAL.—The Secretaries may estab-
lish collaborative agreements with private entities, including group health plans and health insurance issuers, providers, purchasers, consumer organiza-
tions, and entities receiving a grant under section 2908, to—

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

“(B) foster uniformity between the healthcare quality measures utilized in Federal programs and private entities.

“(2) USE OF MEASURES.—The measures adopt-
ed by the Secretaries under this section may apply in one or more disease areas and across delivery set-
tings, in order to improve the quality of care pro-
vided or delivered by private entities.

“(d) COMPARATIVE QUALITY REPORTS.—Beginning on January 1, 2008, in order to make comparative quality information available to healthcare consumers, health pro-
essionals, public health officials, researchers, and other appropriate individuals and entities, the Secretaries and
other relevant agencies shall provide for the aggregation, analysis, and dissemination of quality measures collected under this section. Nothing in this section shall be construed as modifying the privacy standards under the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191).

“(e) EVALUATIONS.—

“(1) ONGOING EVALUATIONS OF USE.—The Secretary shall ensure the ongoing evaluation of the use of the healthcare quality measures adopted under this section.

“(2) EVALUATION AND REPORT.—

“(A) EVALUATION.—The Secretary shall, directly or indirectly through a contract with another entity, conduct an evaluation of the collaborative efforts of the Secretaries to adopt uniform healthcare quality measures and reporting requirements for federally supported healthcare delivery programs as required under this section.

“(B) REPORT.—Not later than 2 years after the date of enactment of this title, the Secretary shall submit a report to the appropriate committees of Congress concerning the
results of the evaluation under subparagraph (A).”.

SEC. 302. VALUE BASED PURCHASING PROGRAMS; SENSE OF THE SENATE.

(a) Medicare Value Based Purchasing Pilot Program.—

(1) IN GENERAL.—The Secretary shall establish under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) a value based purchasing pilot program based on the reporting of quality measures pursuant to those adopted in section 2910 of the Public Health Service Act (as added by section 301) and the overall improvement of healthcare quality through the use of the electronic exchange of health information by entities (including Federally qualified health centers, as defined in section 1861(aa)(4) of the Social Security Act (42 U.S.C. 1395x(aa)(4))) pursuant to the standards adopted under section 2903 of the Public Health Service Act (as added by section 101). Such pilot program should be based on experience gained through previous demonstration projects conducted by the Secretary, including demonstration projects conducted under sections 1866A and 1866C of the Social Security Act (42 U.S.C. 1395cc–1; 1395cc–3), section 649 of the Medicare
Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2322), and other relevant work conducted by private entities.

(2) Expansion.—After conducting the pilot program under paragraph (1) for not less than 2 years, the Secretary may transition and implement such program on a national basis.

(3) Funding.—

(A) In General.—Payments for the costs of carrying out the provisions of this subsection shall be made from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t) (in this subsection referred to as the “Trust Funds”), as determined appropriate by the Secretary.

(B) Limitation to Ensure Budget Neutrality.—The Secretary shall ensure that the total amount of expenditures from the Trust Funds in a year does not exceed the total amount of expenditures from the Trust Funds
that would have been made in such year if this subsection had not been enacted.

(C) MONITORING AND REPORTS.—

(i) ONGOING MONITORING BY THE SECRETARY TO ENSURE FUNDING LIMITATION IS NOT VIOLATED.—The Secretary shall continually monitor expenditures made from the Trust Funds by reason of the provisions of this subsection to ensure that the limitation described in subparagraph (B) is not violated.

(ii) REPORTS.—Not later than April 1 of each year (beginning in the year following the year in which the pilot program under paragraph (1) is implemented), the Secretary shall submit a report to Congress and the Comptroller General of the United States that includes—

(I) a detailed description of—

(aa) the total amount expended from the Trust Funds (including all amounts expended as a result of the provisions of this subsection) during the previous year compared to the total
amount that would have been expended from the Trust Funds during such year if this subsection had not been enacted;

(bb) the projections of the total amount that will be expended from the Trust Funds (including all amounts that will be expended as a result of the provisions of this subsection) during the year in which the report is submitted compared to the total amount that would have been expended from the Trust Funds during the year if this subsection had not been enacted;

and

(cc) specify the steps (if any) that the Secretary will take pursuant to subparagraph (D) to ensure that the limitation described in subparagraph (B) will not be violated; and

(II) a certification from the Chief Actuary of the Centers for Medicare &
Medicaid Services that the descriptions under items (aa), (bb), and (cc) of subclause (I) are reasonable, accurate, and based on generally accepted actuarial principles and methodologies, including that the steps described in subclause (I)(ce) will be adequate to avoid violating the limitation described in subparagraph (B).

(D) APPLICATION OF LIMITATION.—If the Secretary determines that the provisions of this subsection will result in the limitation described in subparagraph (B) being violated in any year, the Secretary shall take appropriate steps to reduce spending that is occurring by reason of such provisions, including through reducing the scope, site, and duration of the pilot project.

(E) AUTHORITY.—The Secretary shall make necessary spending adjustments under the medicare program to recoup amounts so that the limitation described in subparagraph (B) is not violated in any year.

(b) SENSE OF THE SENATE REGARDING PHYSICIAN PAYMENTS UNDER MEDICARE.—It is the sense of the Senate that modifications to the medicare fee schedule for
physicians’ services under section 1848 of the Social Security Act (42 U.S.C. 1394w–4) should include provisions based on the reporting of quality measures pursuant to those adopted in section 2910 of the Public Health Service Act (as added by section 301) and the overall improvement of healthcare quality through the use of the electronic exchange of health information pursuant to the standards adopted under section 2903 of such Act (as added by section 101).

(c) Medicaid Value Based Purchasing Programs.—

(1) In general.—The Secretary shall authorize waivers under section 1115 of the Social Security Act (42 U.S.C. 1315) for States to establish value based purchasing programs for State medicaid programs established under title XIX of such Act (42 U.S.C. 1396 et seq.). Such programs shall be based on the reporting of quality measures pursuant to those adopted in section 2910 of the Public Health Service Act (as added by section 301) and the overall improvement of healthcare quality through the use of the electronic exchange of health information pursuant to the standards adopted under section 2903 of the Public Health Service Act (as added by section 101).
(2) WAIVER.—In authorizing such waivers, the Secretary shall waive any provisions of title XI or XIX of the Social Security Act that would otherwise prevent a State from establishing a value based purchasing program in accordance with paragraph (1).

(d) QUALITY INFORMATION SHARING.—

(1) REVIEW OF MEDICARE CLAIMS DATA.—

(A) PROCEDURES.—In order to improve the quality and efficiency of items and services furnished to Medicare beneficiaries under title XVIII of the Social Security Act, the Secretary shall establish procedures to review claims data submitted under such title with respect to items and services furnished or ordered by physicians.

(B) USE OF MOST RECENT MEDICARE CLAIMS DATA.—In conducting the review under subparagraph (A), the Secretary shall use the most recent claims data that is available to the Secretary.

(2) SHARING OF DATA.—Beginning in 2006, the Secretary shall periodically provide physicians with comparative information on the utilization of items and services under such title XVIII based upon the review of claims data under paragraph (1).
(a) IN GENERAL.—Section 1154(a) of the Social Security Act (42 U.S.C. 1320c–3(a)) is amended by adding at the end the following:

“(18) The organization shall assist, at such time and in such manner as the Secretary may require, healthcare providers (as defined in section 2901 of the Public Health Service Act) in implementing the electronic exchange of health information (as defined in such section 2901).”.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to contracts entered into on or after the date of enactment of this Act.