

109<sup>TH</sup> CONGRESS  
2<sup>D</sup> SESSION

# H. R. 4157

---

## AN ACT

To promote a better health information system.

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

1 **SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.**

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

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

- Sec. 1. Short title and table of contents.
- Sec. 2. Preserving privacy and security laws.

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

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

TITLE II—TRANSACTION STANDARDS, CODES, AND INFORMATION

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

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

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

TITLE IV—ADDITIONAL PROVISIONS

- Sec. 401. Promotion of telehealth services.
- Sec. 402. Study and report on expansion of home health-related telehealth services.

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

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

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

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

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

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

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

19       “(a) ESTABLISHMENT.—There is established within  
20 the Department of Health and Human Services an Office

1 of the National Coordinator for Health Information Tech-  
2 nology that shall be headed by the National Coordinator  
3 for Health Information Technology (referred to in this  
4 part as the ‘National Coordinator’). The National Coordi-  
5 nator shall be appointed by and report directly to the Sec-  
6 retary. The National Coordinator shall be paid at a rate  
7 equal to the rate of basic pay for level IV of the Executive  
8 Schedule.

9 “(b) GOALS OF NATIONWIDE INTEROPERABLE  
10 HEALTH INFORMATION TECHNOLOGY INFRASTRUC-  
11 TURE.—The National Coordinator shall perform the du-  
12 ties under subsection (c) in a manner consistent with the  
13 development of a nationwide interoperable health informa-  
14 tion technology infrastructure that—

15 “(1) improves health care quality, promotes  
16 data accuracy, reduces medical errors, increases the  
17 efficiency of care, and advances the delivery of ap-  
18 propriate, evidence-based health care services;

19 “(2) promotes wellness, disease prevention, and  
20 management of chronic illnesses by increasing the  
21 availability and transparency of information related  
22 to the health care needs of an individual for such in-  
23 dividual;

24 “(3) promotes the availability of appropriate  
25 and accurate information necessary to make medical

1 decisions in a usable form at the time and in the lo-  
2 cation that the medical service involved is provided;

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

7 “(5) promotes a more effective marketplace,  
8 greater competition, greater systems analysis, in-  
9 creased consumer choice, enhanced quality, and im-  
10 proved outcomes in health care services;

11 “(6) with respect to health information of con-  
12 sumers, advances the portability of such information  
13 and the ability of such consumers to share and use  
14 such information to assist in the management of  
15 their health care;

16 “(7) improves the coordination of information  
17 and the provision of such services through an effec-  
18 tive infrastructure for the secure and authorized ex-  
19 change and use of health care information;

20 “(8) provides for the confidentiality and secu-  
21 rity of individually identifiable health information,  
22 consistent with legally applicable requirements with  
23 respect to securing and protecting the confidentiality  
24 of individually identifiable health information of a  
25 patient;

1           “(9) promotes the creation and maintenance of  
2           transportable, secure, Internet-based personal health  
3           records, including promoting the efforts of health  
4           care payers and health plan administrators for a  
5           health plan, such as Federal agencies, private health  
6           plans, and third party administrators, to provide for  
7           such records on behalf of members of such a plan;

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

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

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

15           “(13) improves the availability of information  
16           and resources for individuals with low or limited lit-  
17           eracy or language skills.

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

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

1           “(2) PRINCIPAL ADVISOR TO THE SEC-  
2           RETARY.—The National Coordinator shall serve as  
3           the principal advisor to the Secretary on the develop-  
4           ment, application, and use of health information  
5           technology, and shall coordinate the policies and pro-  
6           grams of the Department of Health and Human  
7           Services for promoting the use of health information  
8           technology.

9           “(3) INTRAGOVERNMENTAL COORDINATOR.—  
10          The National Coordinator shall ensure that health  
11          information technology policies and programs of the  
12          Department of Health and Human Services are co-  
13          ordinated with those of relevant executive branch  
14          agencies and departments with a goal to avoid dupli-  
15          cation of effort, to align the health information ar-  
16          chitecture of each agency or department toward a  
17          common approach, to ensure that each agency or de-  
18          partment conducts programs within the areas of its  
19          greatest expertise and its mission in order to create  
20          a national interoperable health information system  
21          capable of meeting national public health needs ef-  
22          fectively and efficiently, and to assist Federal agen-  
23          cies and departments in security programs, policies,  
24          and protections to prevent unauthorized access to in-  
25          dividually identifiable health information created,

1 maintained, or in the temporary possession of that  
2 agency or department. The coordination authority  
3 provided to the National Coordinator under the pre-  
4 vious sentence shall supercede any such authority  
5 otherwise provided to any other official of the De-  
6 partment of Health and Human Services. For the  
7 purposes of this paragraph, the term ‘unauthorized  
8 access’ means access that is not authorized by that  
9 agency or department including unauthorized em-  
10 ployee access.

11 “(4) ADVISOR TO OMB.—The National Coordi-  
12 nator shall provide to the Director of the Office of  
13 Management and Budget comments and advice with  
14 respect to specific Federal health information tech-  
15 nology programs.

16 “(5) PROMOTER OF HEALTH INFORMATION  
17 TECHNOLOGY IN MEDICALLY UNDERSERVED COMMU-  
18 NITIES.—The National Coordinator shall—

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

1           “(B) coordinate with the funding sources  
2           to help such communities connect to identified  
3           funding; and

4           “(C) collaborate with the Agency for  
5           Healthcare Research and Quality and the  
6           Health Services Resources Administration and  
7           other Federal agencies to support technical as-  
8           sistance, knowledge dissemination, and resource  
9           development, to medically underserved commu-  
10          nities seeking to plan for and adopt technology  
11          and establish electronic health information net-  
12          works across providers.”.

13          (b) TREATMENT OF EXECUTIVE ORDER NO.  
14 13335.—Executive Order No. 13335 shall not have any  
15 force or effect after the date of the enactment of this Act.

16          (c) TRANSITION FROM ONCHIT UNDER EXECUTIVE  
17 ORDER.—

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

1 Office of the new National Coordinator as of the  
2 date of the enactment of this Act.

3 (2) RULE OF CONSTRUCTION.— Nothing in this  
4 section or the amendment made by this section shall  
5 be construed as requiring the duplication of Federal  
6 efforts with respect to the establishment of the Of-  
7 fice of the National Coordinator for Health Informa-  
8 tion Technology, regardless of whether such efforts  
9 are carried out before or after the date of the enact-  
10 ment of this Act.

11 (3) ACTING NATIONAL COORDINATOR.—Before  
12 the appointment of the new National Coordinator,  
13 the old National Coordinator shall act as the Na-  
14 tional Coordinator for Health Information Tech-  
15 nology until the office is filled as provided in section  
16 271(a) of the Public Health Service Act, as added  
17 by subsection (a). The Secretary of Health and  
18 Human Services may appoint the old National Coor-  
19 dinator as the new National Coordinator.

20 (4) DEFINITIONS.—For purposes of this sub-  
21 section:

22 (A) NEW NATIONAL COORDINATOR.—The  
23 term “new National Coordinator” means the  
24 National Coordinator for Health Information  
25 Technology appointed under section 271(a) of

1 the Public Health Service Act, as added by sub-  
2 section (a).

3 (B) OLD NATIONAL COORDINATOR.—The  
4 term “old National Coordinator” means the  
5 National Coordinator for Health Information  
6 Technology appointed under Executive Order  
7 No. 13335.

8 (d) STUDY OF HEALTH INFORMATION TECHNOLOGY  
9 IN MEDICALLY UNDERSERVED COMMUNITIES.—

10 (1) STUDY.—The National Coordinator for  
11 Health Information Technology shall conduct a  
12 study on the development and implementation of  
13 health information technology in medically under-  
14 served communities. The study shall—

15 (A) identify barriers to successful imple-  
16 mentation of health information technology in  
17 these communities;

18 (B) examine the impact of health informa-  
19 tion technology on providing quality care and  
20 reducing the cost of care to these communities;

21 (C) examine urban and rural community  
22 health systems and determine the impact that  
23 health information technology may have on the  
24 capacity of primary health providers; and

1 (D) assess the feasibility and the costs of  
2 associated with the use of health information  
3 technology in these communities.

4 (2) REPORT.—Not later than 18 months after  
5 the date of the enactment of this Act, the National  
6 Coordinator shall submit to Congress a report on the  
7 study conducted under paragraph (1) and shall in-  
8 clude in such report such recommendations for legis-  
9 lation or administrative action as the Coordinator  
10 determines appropriate.

11 **SEC. 102. REPORT ON THE AMERICAN HEALTH INFORMA-**  
12 **TION COMMUNITY.**

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

19 (1) A description of the accomplishments of  
20 AHIC, with respect to the promotion of the develop-  
21 ment of national guidelines, the development of a  
22 nationwide health information network, and the in-  
23 creased adoption of health information technology.

24 (2) Information on how model privacy and secu-  
25 rity policies may be used to protect confidentiality of

1 health information, and an assessment of how exist-  
2 ing policies compare to such model policies.

3 (3) Information on the progress in—

4 (A) establishing uniform industry-wide  
5 health information technology standards;

6 (B) achieving an internet-based nationwide  
7 health information network;

8 (C) achieving interoperable electronic  
9 health record adoption across health care pro-  
10 viders; and

11 (D) creating technological innovations to  
12 promote security and confidentiality of individ-  
13 ually identifiable health information.

14 (4) Recommendations for the transition of  
15 AHIC to a longer-term or permanent advisory and  
16 facilitation entity, including—

17 (A) a schedule for such transition;

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

20 (C) the collaborative role of the Federal  
21 Government in the entity;

22 (D) steps for—

23 (i) continued leadership in the facilita-  
24 tion of guidelines or standards;

1 (ii) the alignment of financial incen-  
2 tives; and

3 (iii) the long-term plan for health care  
4 transformation through information tech-  
5 nology; and

6 (E) the elimination or revision of the func-  
7 tions of AHIC during the development of the  
8 nationwide health information network.

9 (5) Recommendations on the inclusion of emer-  
10 gency contact or next-of-kin information (including  
11 name and phone number) in interoperable electronic  
12 health records.

13 **SEC. 103. INTEROPERABILITY PLANNING PROCESS; FED-**  
14 **ERAL INFORMATION COLLECTION ACTIVI-**  
15 **TIES.**

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

19 **“SEC. 272. INTEROPERABILITY PLANNING PROCESS; FED-**  
20 **ERAL INFORMATION COLLECTION ACTIVI-**  
21 **TIES.**

22 **“(a) STRATEGIC INTEROPERABILITY PLANNING**  
23 **PROCESS.—**

24 **“(1) ASSESSMENT AND ENDORSEMENT OF**  
25 **CORE STRATEGIC GUIDELINES.—**

1           “(A) IN GENERAL.—Not later than De-  
2 cember 31, 2006, the National Coordinator  
3 shall publish a strategic plan, including a sched-  
4 ule, for the assessment and the endorsement of  
5 core interoperability guidelines for significant  
6 use cases consistent with this subsection. The  
7 National Coordinator may update such plan  
8 from time to time.

9           “(B) ENDORSEMENT.—

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

23           “(ii) CONSULTATION.—All such en-  
24 dorsements shall be in consultation with

1 the American Health Information Commu-  
2 nity and other appropriate entities.

3 “(iii) VOLUNTARY COMPLIANCE.—  
4 Compliance with such guidelines shall be  
5 voluntary, subject to subsection (b)(1).

6 “(C) CONSULTATION WITH OTHER PAR-  
7 TIES.—The National Coordinator shall develop  
8 and implement such strategic plan in consulta-  
9 tion with the American Health Information  
10 Community and other appropriate entities.

11 “(D) DEFINITIONS.—For purposes of this  
12 section:

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

1           “(ii) CORE INTEROPERABILITY GUIDE-  
2           LINE.—The term ‘core interoperability  
3           guideline’ means an interoperability guide-  
4           line that the National Coordinator deter-  
5           mines is essential and necessary for pur-  
6           poses described in clause (i).

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

16          “(2) NATIONAL SURVEY.—

17                 “(A) IN GENERAL.—Not later than August  
18                 31, 2008, the National Coordinator shall con-  
19                 duct one or more surveys designed to measure  
20                 the capability of entities (including Federal  
21                 agencies, State and local government agencies,  
22                 and private sector entities) to exchange elec-  
23                 tronic health information by appropriate signifi-  
24                 cant use case. Such surveys shall identify the  
25                 extent to which the type of health information,

1 the use for such information, or any other ap-  
2 propriate characterization of such information  
3 may relate to the capability of such entities to  
4 exchange health information in a manner that  
5 is consistent with methods to improve the inter-  
6 operability of health information and with core  
7 interoperability guidelines.

8 “(B) DISSEMINATION OF SURVEY RE-  
9 SULTS.—The National Coordinator shall dis-  
10 seminate the results of such surveys in a man-  
11 ner so as to—

12 “(i) inform the public on the capabili-  
13 ties of entities to exchange electronic  
14 health information;

15 “(ii) assist in establishing a more  
16 interoperable information architecture; and

17 “(iii) identify the status of health in-  
18 formation systems used in Federal agen-  
19 cies and the status of such systems with  
20 respect to interoperability guidelines.

21 “(b) FEDERAL HEALTH INFORMATION COLLECTION  
22 ACTIVITIES.—

23 “(1) REQUIREMENTS.—With respect to a core  
24 interoperability guideline endorsed under subsection  
25 (a)(1)(B) for a significant use case, the President

1 shall take measures to ensure that Federal activities  
2 involving the broad collection and submission of  
3 health information are consistent with such guideline  
4 within three years after the date of such endorse-  
5 ment.

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

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

1 mining such appropriate measures. In addition,  
2 the President, in consultation with the Sec-  
3 retary, shall encourage voluntary private and  
4 public sector efforts to allow access to such use-  
5 ful categories of non-identifiable health infor-  
6 mation to advance health care quality and  
7 health research.

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

20 “(3) ANNUAL REVIEW AND REPORT.—For each  
21 year during the five-year period following the date of  
22 the enactment of this section, the National Coordi-  
23 nator shall review the operation of health informa-  
24 tion collection by and submission to the Federal gov-  
25 ernment and the purchases (and planned purchases)

1 of health information technology by the Federal gov-  
2 ernment. For each such year and based on the re-  
3 view for such year, the National Coordinator shall  
4 submit to the President and Congress recommenda-  
5 tions on methods to—

6 “(A) streamline (and eliminate redundancy  
7 in) Federal systems used for the collection and  
8 submission of health information;

9 “(B) improve efficiency in such collection  
10 and submission;

11 “(C) increase the ability to assess health  
12 care quality; and

13 “(D) reduce health care costs.”.

14 **SEC. 104. GRANTS TO INTEGRATED HEALTH SYSTEMS TO**  
15 **PROMOTE HEALTH INFORMATION TECH-**  
16 **NOLOGIES TO IMPROVE COORDINATION OF**  
17 **CARE FOR THE UNINSURED, UNDERINSURED,**  
18 **AND MEDICALLY UNDERSERVED.**

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

1 **“SEC. 330M. GRANTS FOR IMPROVEMENT OF THE COORDI-**  
2 **NATION OF CARE FOR THE UNINSURED,**  
3 **UNDERINSURED, AND MEDICALLY UNDER-**  
4 **SERVED.**

5 “(a) IN GENERAL.—The Secretary may make grants  
6 to integrated health care systems, in accordance with this  
7 section, for projects to better coordinate the provision of  
8 health care through the adoption of new health informa-  
9 tion technology, or the significant improvement of existing  
10 health information technology, to improve the provision of  
11 health care to uninsured, underinsured, and medically un-  
12 derserved individuals (including in urban and rural areas)  
13 through health-related information about such individuals,  
14 throughout such a system and at the point of service.

15 “(b) ELIGIBILITY.—

16 “(1) APPLICATION.—To be eligible to receive a  
17 grant under this section, an integrated health care  
18 system shall prepare and submit to the Secretary an  
19 application, at such time, in such manner, and con-  
20 taining such information as the Secretary may re-  
21 quire, including—

22 “(A) a description of the project that the  
23 system will carry out using the funds provided  
24 under the grant;

1           “(B) a description of the manner in which  
2           the project funded under the grant will advance  
3           the goal specified in subsection (a); and

4           “(C) a description of the populations to be  
5           served by the adoption or improvement of  
6           health information technology.

7           “(2) OPTIONAL REPORTING CONDITION.—The  
8           Secretary may also condition the provision of a  
9           grant to an integrated health care system under this  
10          section for a project on the submission by such sys-  
11          tem to the Secretary of a report on the impact of  
12          the health information technology adopted (or im-  
13          proved) under such project on the delivery of health  
14          care and the quality of care (in accordance with ap-  
15          plicable measures of such quality). Such report shall  
16          be at such time and in such form and manner as  
17          specified by the Secretary.

18          “(c) INTEGRATED HEALTH CARE SYSTEM DE-  
19          FINED.—For purposes of this section, the term ‘integrated  
20          health care system’ means a system of health care pro-  
21          viders that is organized to provide care in a coordinated  
22          fashion and has a demonstrated commitment to provide  
23          uninsured, underinsured, and medically underserved indi-  
24          viduals with access to such care.

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

4               “(1) that can demonstrate past successful com-  
5 munity-wide efforts to improve the quality of care  
6 provided and the coordination of care for the unin-  
7 sured, underinsured, and medically underserved;

8               “(2) if the project to be funded through such a  
9 grant—

10                       “(A) will improve the delivery of health  
11 care and the quality of care provided; and

12                       “(B) will demonstrate savings for State or  
13 Federal health care benefits programs or enti-  
14 ties legally obligated under Federal law to pro-  
15 vide health care from the reduction of duplica-  
16 tive health care services, administrative costs,  
17 and medical errors; or

18               “(3) if the project to be funded through such a  
19 grant will emphasize the improvement of access to  
20 medical care and medical care for medically under-  
21 served populations which are geographically isolated  
22 or located in underserved urban areas.

23       “(e) LIMITATION, MATCHING REQUIREMENT, AND  
24 CONDITIONS.—

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

7           “(2) MATCHING REQUIREMENT.—To be eligible  
8 for a grant under this section an integrated health  
9 care system shall contribute non-Federal contribu-  
10 tions to the costs of carrying out the project for  
11 which the grant is awarded in an amount equal to  
12 \$1 for each \$5 of Federal funds provided under the  
13 grant.

14           “(f) AUTHORIZATION OF APPROPRIATIONS.—There  
15 are authorized to be appropriated to carry out this section  
16 \$15,000,000 for each of fiscal years 2007 and 2008.”.

17 **SEC. 105. SMALL PHYSICIAN PRACTICE DEMONSTRATION**  
18 **GRANTS.**

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

22 **“SEC. 273. SMALL PHYSICIAN PRACTICE DEMONSTRATION**  
23 **GRANTS.**

24           “(a) IN GENERAL.—The Secretary shall establish a  
25 demonstration program under which the Secretary makes

1 grants to small physician practices (including such prac-  
2 tices that furnish services to individuals with chronic ill-  
3 nesses) that are located in rural areas or medically under-  
4 served urban areas for the purchase and support of health  
5 information technology.

6 “(b) ELIGIBILITY.—To be eligible to receive a grant  
7 under this section, an applicant shall prepare and submit  
8 to the Secretary an application, at such time, in such man-  
9 ner, and containing such information, as the Secretary  
10 may require.

11 “(c) REPORTING.—

12 “(1) REQUIRED REPORTS BY SMALL PHYSICIAN  
13 PRACTICES.—A small physician practice receiving a  
14 grant under subsection (a) shall submit to the Sec-  
15 retary an evaluation on the health information tech-  
16 nology funded by such grant. Such evaluation shall  
17 include information on—

18 “(A) barriers to the adoption of health in-  
19 formation technology by the small physician  
20 practice;

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

23 “(C) the effect health information tech-  
24 nology will have on the quality of health care  
25 furnished by such practice; and

1           “(D) the effect of any medical liability  
2 rules on such practice.

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

7           “(d) AUTHORIZATION OF APPROPRIATIONS.—There  
8 are authorized to be appropriated to carry out this section  
9 \$5,000,000 for each of fiscal years 2007 and 2008.”.

10 **TITLE II—TRANSACTION STAND-**  
11 **ARDS, CODES, AND INFORMA-**  
12 **TION**

13 **SEC. 201. PROCEDURES TO ENSURE TIMELY UPDATING OF**  
14 **STANDARDS THAT ENABLE ELECTRONIC EX-**  
15 **CHANGES.**

16           Section 1174(b) of the Social Security Act (42 U.S.C.  
17 1320d–3(b)) is amended—

18           (1) in paragraph (1)—

19           (A) in the first sentence, by inserting “and  
20 in accordance with paragraph (3)” before the  
21 period; and

22           (B) by adding at the end the following new  
23 sentence: “For purposes of this subsection and  
24 section 1173(c)(2), the term ‘modification’ in-

1           cludes a new version or a version upgrade.”;  
2           and

3           (2) by adding at the end the following new  
4 paragraph:

5           “(3) EXPEDITED PROCEDURES FOR ADOPTION  
6 OF ADDITIONS AND MODIFICATIONS TO STAND-  
7 ARDS.—

8           “(A) IN GENERAL.—For purposes of para-  
9 graph (1), the Secretary shall provide for an ex-  
10 pedited upgrade program (in this paragraph re-  
11 ferred to as the ‘upgrade program’), in accord-  
12 ance with this paragraph, to develop and ap-  
13 prove additions and modifications to the stand-  
14 ards adopted under section 1173(a) to improve  
15 the quality of such standards or to extend the  
16 functionality of such standards to meet evolving  
17 requirements in health care.

18           “(B) PUBLICATION OF NOTICES.—Under  
19 the upgrade program:

20           “(i) VOLUNTARY NOTICE OF INITI-  
21 ATION OF PROCESS.—Not later than 30  
22 days after the date the Secretary receives  
23 a notice from a standard setting organiza-  
24 tion that the organization is initiating a  
25 process to develop an addition or modifica-

1           tion to a standard adopted under section  
2           1173(a), the Secretary shall publish a no-  
3           tice in the Federal Register that—

4                   “(I) identifies the subject matter  
5                   of the addition or modification;

6                   “(II) provides a description of  
7                   how persons may participate in the  
8                   development process; and

9                   “(III) invites public participation  
10                  in such process.

11                  “(ii) VOLUNTARY NOTICE OF PRE-  
12                  LIMINARY DRAFT OF ADDITIONS OR MODI-  
13                  FICATIONS TO STANDARDS.—Not later  
14                  than 30 days after the date of the date the  
15                  Secretary receives a notice from a standard  
16                  setting organization that the organization  
17                  has prepared a preliminary draft of an ad-  
18                  dition or modification to a standard adopt-  
19                  ed by section 1173(a), the Secretary shall  
20                  publish a notice in the Federal Register  
21                  that—

22                   “(I) identifies the subject matter  
23                   of (and summarizes) the addition or  
24                   modification;

1                   “(II) specifies the procedure for  
2                   obtaining the draft;

3                   “(III) provides a description of  
4                   how persons may submit comments in  
5                   writing and at any public hearing or  
6                   meeting held by the organization on  
7                   the addition or modification; and

8                   “(IV) invites submission of such  
9                   comments and participation in such  
10                  hearing or meeting without requiring  
11                  the public to pay a fee to participate.

12                  “(iii) NOTICE OF PROPOSED ADDITION  
13                  OR MODIFICATION TO STANDARDS.—Not  
14                  later than 30 days after the date of the  
15                  date the Secretary receives a notice from a  
16                  standard setting organization that the or-  
17                  ganization has a proposed addition or  
18                  modification to a standard adopted under  
19                  section 1173(a) that the organization in-  
20                  tends to submit under subparagraph  
21                  (D)(iii), the Secretary shall publish a no-  
22                  tice in the Federal Register that contains,  
23                  with respect to the proposed addition or  
24                  modification, the information required in

1           the notice under clause (ii) with respect to  
2           the addition or modification.

3           “(iv) CONSTRUCTION.—Nothing in  
4           this paragraph shall be construed as re-  
5           quiring a standard setting organization to  
6           request the notices described in clauses (i)  
7           and (ii) with respect to an addition or  
8           modification to a standard in order to  
9           qualify for an expedited determination  
10          under subparagraph (C) with respect to a  
11          proposal submitted to the Secretary for  
12          adoption of such addition or modification.

13          “(C) PROVISION OF EXPEDITED DETER-  
14          MINATION.—Under the upgrade program and  
15          with respect to a proposal by a standard setting  
16          organization for an addition or modification to  
17          a standard adopted under section 1173(a), if  
18          the Secretary determines that the standard set-  
19          ting organization developed such addition or  
20          modification in accordance with the require-  
21          ments of subparagraph (D) and the National  
22          Committee on Vital and Health Statistics rec-  
23          ommends approval of such addition or modifica-  
24          tion under subparagraph (E), the Secretary

1 shall provide for expedited treatment of such  
2 proposal in accordance with subparagraph (F).

3 “(D) REQUIREMENTS.—The requirements  
4 under this subparagraph with respect to a pro-  
5 posed addition or modification to a standard by  
6 a standard setting organization are the fol-  
7 lowing:

8 “(i) REQUEST FOR PUBLICATION OF  
9 NOTICE.—The standard setting organiza-  
10 tion submits to the Secretary a request for  
11 publication in the Federal Register of a no-  
12 tice described in subparagraph (B)(iii) for  
13 the proposed addition or modification.

14 “(ii) PROCESS FOR RECEIPT AND  
15 CONSIDERATION OF PUBLIC COMMENT.—  
16 The standard setting organization provides  
17 for a process through which, after the pub-  
18 lication of the notice referred to under  
19 clause (i), the organization—

20 “(I) receives and responds to  
21 public comments submitted on a time-  
22 ly basis on the proposed addition or  
23 modification before submitting such  
24 proposed addition or modification to

1 the National Committee on Vital and  
2 Health Statistics under clause (iii);

3 “(II) makes publicly available a  
4 written explanation for its response in  
5 the proposed addition or modification  
6 to comments submitted on a timely  
7 basis; and

8 “(III) makes public comments re-  
9 ceived under clause (I) available, or  
10 provides access to such comments, to  
11 the Secretary.

12 “(iii) SUBMITTAL OF FINAL PRO-  
13 POSED ADDITION OR MODIFICATION TO  
14 NCVHS.—After completion of the process  
15 under clause (ii), the standard setting or-  
16 ganization submits the proposed addition  
17 or modification to the National Committee  
18 on Vital and Health Statistics for review  
19 and consideration under subparagraph (E).  
20 Such submission shall include information  
21 on the organization’s compliance with the  
22 notice and comment requirements (and re-  
23 sponses to those comments) under clause  
24 (ii).

1           “(E) HEARING AND RECOMMENDATIONS  
2 BY NATIONAL COMMITTEE ON VITAL AND  
3 HEALTH STATISTICS.—Under the upgrade pro-  
4 gram, upon receipt of a proposal submitted by  
5 a standard setting organization under subpara-  
6 graph (D)(iii) for the adoption of an addition or  
7 modification to a standard, the National Com-  
8 mittee on Vital and Health Statistics shall pro-  
9 vide notice to the public and a reasonable op-  
10 portunity for public testimony at a hearing on  
11 such addition or modification. The Secretary  
12 may participate in such hearing in such capac-  
13 ity (including presiding ex officio) as the Sec-  
14 retary shall determine appropriate. Not later  
15 than 120 days after the date of receipt of the  
16 proposal, the Committee shall submit to the  
17 Secretary its recommendation to adopt (or not  
18 adopt) the proposed addition or modification.

19           “(F) DETERMINATION BY SECRETARY TO  
20 ACCEPT OR REJECT NATIONAL COMMITTEE ON  
21 VITAL AND HEALTH STATISTICS RECOMMENDA-  
22 TION.—

23           “(i) TIMELY DETERMINATION.—  
24 Under the upgrade program, if the Na-  
25 tional Committee on Vital and Health Sta-

1           tistics submits to the Secretary a rec-  
2           ommendation under subparagraph (E) to  
3           adopt a proposed addition or modification,  
4           not later than 90 days after the date of re-  
5           ceipt of such recommendation the Sec-  
6           retary shall make a determination to ac-  
7           cept or reject the recommendation and  
8           shall publish notice of such determination  
9           in the Federal Register not later than 30  
10          days after the date of the determination.

11           “(ii) CONTENTS OF NOTICE.—If the  
12          determination is to reject the recommenda-  
13          tion, such notice shall include the reasons  
14          for the rejection. If the determination is to  
15          accept the recommendation, as part of  
16          such notice the Secretary shall promulgate  
17          the modified standard (including the ac-  
18          cepted proposed addition or modification  
19          accepted) as a final rule under this sub-  
20          section without any further notice or public  
21          comment period.

22           “(iii) LIMITATION ON CONSIDER-  
23          ATION.—The Secretary shall not consider a  
24          proposal under this subparagraph unless  
25          the Secretary determines that the require-

1           ments of subparagraph (D) (including pub-  
2           lication of notice and opportunity for pub-  
3           lic comment) have been met with respect to  
4           the proposal.

5           “(G) EXEMPTION FROM PAPERWORK RE-  
6           DUCTION ACT.—Chapter 35 of title 44, United  
7           States Code, shall not apply to a final rule pro-  
8           mulgated under subparagraph (F).

9           “(H) TREATMENT AS SATISFYING RE-  
10          QUIREMENTS FOR NOTICE-AND-COMMENT.—  
11          Any requirements under section 553 of title 5,  
12          United States Code, relating to notice and an  
13          opportunity for public comment with respect to  
14          a final rule promulgated under subparagraph  
15          (F) shall be treated as having been met by  
16          meeting the requirements of the notice and op-  
17          portunity for public comment provided under  
18          provisions of subparagraphs (B)(iii), (D), and  
19          (E).

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

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

24          (a) IN GENERAL.—The Secretary of Health and  
25          Human Services shall provide by notice published in the

1 Federal Register for the following replacements of stand-  
2 ards to apply to transactions occurring on or after April  
3 1, 2009:

4 (1) ACCREDITED STANDARDS COMMITTEE X12  
5 (ASC X12) STANDARD.—The replacement of the Ac-  
6 credited Standards Committee X12 (ASC X12)  
7 version 4010 adopted under section 1173(a) of such  
8 Act (42 U.S.C. 1320d–2(a)) with the ASC X12  
9 version 5010, as reviewed by the National Com-  
10 mittee on Vital Health Statistics.

11 (2) NATIONAL COUNCIL FOR PRESCRIPTION  
12 DRUG PROGRAMS (NCPDP) TELECOMMUNICATIONS  
13 STANDARDS.—The replacement of the National  
14 Council for Prescription Drug Programs (NCPDP)  
15 Telecommunications Standards version 5.1 adopted  
16 under section 1173(a) of such Act (42 U.S.C.  
17 1320d–2(a)) with whichever is the latest version of  
18 the NCPDP Telecommunications Standards that has  
19 been approved by such Council and reviewed by the  
20 National Committee on Vital Health Statistics as of  
21 April 1, 2007.

22 (b) NO JUDICIAL REVIEW.—The implementation of  
23 subsection (a), including the determination of the latest  
24 version under subsection (a)(2), shall not be subject to ju-  
25 dicial review.

1 **SEC. 203. UPGRADING ICD CODES; CODING AND DOCU-**  
2 **MENTATION OF NON-MEDICAL INFORMA-**  
3 **TION.**

4 (a) UPGRADING ICD CODES.—

5 (1) IN GENERAL.—The Secretary of Health and  
6 Human Services shall provide by notice published in  
7 the Federal Register for the replacement of the  
8 International Classification of Diseases, 9th revision,  
9 Clinical Modification (ICD–9-CM) under the regula-  
10 tion promulgated under section 1173(e) of the Social  
11 Security Act (42 U.S.C. 1320d–2(c)), including for  
12 purposes of part A of title XVIII of such Act, with  
13 both of the following:

14 (A) The International Classification of  
15 Diseases, 10th revision, Clinical Modification  
16 (ICD–10-CM).

17 (B) The International Classification of  
18 Diseases, 10th revision, Procedure Coding Sys-  
19 tem (ICD–10-PCS).

20 (2) APPLICATION.—The replacement made by  
21 paragraph (1) shall apply, for purposes of section  
22 1175(b)(2) of the Social Security Act (42 U.S.C.  
23 1320d–4(b)(2)), to services furnished on or after Oc-  
24 tober 1, 2010.

25 (3) RULES OF CONSTRUCTION.—Nothing in  
26 paragraph (1) shall be construed—

1 (A) as affecting the application of classi-  
2 fication methodologies or codes, such as CPT or  
3 HCPCS codes, other than under the Inter-  
4 national Classification of Diseases (ICD); or

5 (B) as superseding the authority of the  
6 Secretary of Health and Human Services to  
7 maintain and modify the coding set for ICD-  
8 10-CM and ICD-10-PCS, including under the  
9 amendments made by section 201.

10 (b) CODING AND DOCUMENTATION OF NON-MEDICAL  
11 INFORMATION.—In any regulation or other action imple-  
12 menting the International Classification of Diseases, 10th  
13 revision, Clinical Modification (ICD-10-CM), the Inter-  
14 national Classification of Diseases, 10th revision, Proce-  
15 dure Coding System (ICD-10-PCS), or other version of  
16 the International Classification of Diseases, 10th revision,  
17 the Secretary of Health and Human Services shall ensure  
18 that no health care provider is required to code to a level  
19 of specificity that would require documentation of non-  
20 medical information on the external cause of any given  
21 type of injury.

1 **SEC. 204. STRATEGIC PLAN FOR COORDINATING IMPLE-**  
2 **MENTATION OF TRANSACTION STANDARDS**  
3 **AND ICD CODES.**

4 Not later than the date that is 180 days after the  
5 date of the enactment of this Act, the Secretary of Health  
6 and Human Services, in consultation with relevant public  
7 and private entities, shall develop a strategic plan with re-  
8 spect to the need for coordination in the implementation  
9 of—

10 (1) transaction standards under section 1173(a)  
11 of the Social Security Act, including modifications to  
12 such standards under section 1174(b)(3) of such  
13 Act, as added by section 201; and

14 (2) any updated versions of the International  
15 Classification of Diseases (ICD), including the re-  
16 placement of ICD–9 provided for under section  
17 203(a).

18 **SEC. 205. STUDY AND REPORT TO DETERMINE IMPACT OF**  
19 **VARIATION AND COMMONALITY IN STATE**  
20 **HEALTH INFORMATION LAWS AND REGULA-**  
21 **TIONS.**

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

1 “STUDY AND REPORT TO DETERMINE IMPACT OF VARI-  
2 ATION AND COMMONALITY IN STATE HEALTH INFOR-  
3 MATION LAWS AND REGULATIONS

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

15 “(1)(A) the degree of variation and com-  
16 monality among the requirements of such laws for  
17 States; and

18 “(B) the degree of variation and commonality  
19 between the requirements of such laws and the cur-  
20 rent Federal standards;

21 “(2) insofar as there is variation among and be-  
22 tween such requirements, the strengths and weak-  
23 nesses of such requirements; and

24 “(3) the extent to which such variation may ad-  
25 versely impact the secure, confidential, and timely

1 exchange of health information among States, the  
2 Federal government, and public and private entities,  
3 or may otherwise impact the reliability of such infor-  
4 mation.

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

9 “(1) ANALYSIS OF NEED FOR GREATER COM-  
10 MONALITY.—A determination by the Secretary on  
11 the extent to which there is a need for greater com-  
12 monality of the requirements of State security and  
13 confidentiality laws and current Federal security and  
14 confidentiality standards to better protect, strength-  
15 en, or otherwise improve the secure, confidential,  
16 and timely exchange of health information among  
17 States, the Federal government, and public and pri-  
18 vate entities.

19 “(2) RECOMMENDATIONS FOR GREATER COM-  
20 MONALITY.—Insofar as the Secretary determines  
21 under paragraph (1) that there is a need for greater  
22 commonality of such requirements, recommendations  
23 on the extent to which (and how) the current Fed-  
24 eral security and confidentiality standards should be  
25 changed in order to provide the commonality needed

1 to better protect, strengthen, or otherwise improve  
2 the secure, confidential, and timely exchange of  
3 health information.

4 “(3) SPECIFIC RECOMMENDATION ON LEGISLA-  
5 TIVE CHANGES FOR GREATER COMMONALITY.—A  
6 specific recommendation on the extent to which and  
7 how such standards should supersede State laws, in  
8 order to provide the commonality needed to better  
9 protect or strengthen the security and confidentiality  
10 of health information in the timely exchange of such  
11 information and legislative language in the form of  
12 a bill to effectuate such specific recommendation.

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

15 “(1) RULES OF HOUSE OF REPRESENTATIVES  
16 AND SENATE.—This subsection is enacted by the  
17 Congress—

18 “(A) as an exercise of the rulemaking  
19 power of the House of Representatives and the  
20 Senate, respectively, and as such they are  
21 deemed a part of the rules of each House, re-  
22 spectively, but applicable only with respect to  
23 the procedure to be followed in that House in  
24 the case of a greater commonality bill defined  
25 in paragraph (4), and they supersede other

1 rules only to the extent that they are incon-  
2 sistent therewith; and

3 “(B) with full recognition of the constitu-  
4 tional right of either House to change the rules  
5 (so far as relating to the procedure of that  
6 House) at any time, in the same manner and  
7 to the same extent as in the case of any other  
8 rule of that House.

9 “(2) INTRODUCTION.—On the date on which  
10 the final report is submitted under subsection  
11 (b)(3)—

12 “(A) a greater commonality bill shall be in-  
13 troduced (by request) in the House by the ma-  
14 jority leader of the House, for himself and the  
15 minority leader of the House, or by Members of  
16 the House designated by the majority leader  
17 and minority leader of the House; and

18 “(B) a greater commonality bill shall be  
19 introduced (by request) in the Senate by the  
20 majority leader of the Senate, for himself and  
21 the minority leader of the Senate, or by Mem-  
22 bers of the Senate designated by the majority  
23 leader and minority leader of the Senate.

24 If either House is not in session on the day on which  
25 such a report is submitted, the greater commonality

1 bill shall be introduced in that House, as provided  
2 in the preceding sentence, on the first day thereafter  
3 on which the House is in session.

4 “(3) REFERRAL.—A greater commonality bill  
5 shall be referred by the Presiding Officers of the re-  
6 spective House to the appropriate committee (or  
7 committees) of such House, in accordance with the  
8 rules of that House.

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

12 “(A) the title of which is the following: ‘A  
13 Bill to provide the commonality needed to bet-  
14 ter protect, strengthen, or otherwise improve  
15 the secure, confidential, and timely exchange of  
16 health information’; and

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

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

21 “(1) CURRENT FEDERAL SECURITY AND CON-  
22 FIDENTIALITY STANDARDS.—The term ‘current Fed-  
23 eral security and confidentiality standards’ means  
24 the Federal privacy standards established pursuant  
25 to section 264(c) of the Health Insurance Portability

1 and Accountability Act of 1996 (42 U.S.C. 1320d–  
2 note) and security standards established under  
3 section 1173(d) of the Social Security Act.

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

8 “(3) STATE SECURITY AND CONFIDENTIALITY  
9 LAWS.—The term ‘State security and confidentiality  
10 laws’ means State laws and regulations relating to  
11 the privacy and confidentiality of health information  
12 or to the security of such information.”.

13 **SEC. 206. REPORT ON APPROPRIATENESS OF CLASSIFICA-**  
14 **TION METHODOLOGIES AND CODES FOR AD-**  
15 **DITIONAL PURPOSES.**

16 Not later than the date that is 180 days after the  
17 date of the enactment of this Act, the Secretary of Health  
18 and Human Services shall submit to Congress a report  
19 that evaluates—

20 (1) the applicability of health care classification  
21 methodologies and codes for purposes beyond the  
22 coding of services for diagnostic documentation or  
23 billing purposes;

1           (2) the usefulness, accuracy, and completeness  
2 of such methodologies and codes for such purposes;  
3 and

4           (3) the capacity of such methodologies and  
5 codes to produce erroneous or misleading informa-  
6 tion, with respect to such purposes.

7 **TITLE III—PROMOTING THE USE**  
8 **OF HEALTH INFORMATION**  
9 **TECHNOLOGY TO BETTER CO-**  
10 **ORDINATE HEALTH CARE**

11 **SEC. 301. SAFE HARBORS TO ANTIKICKBACK CIVIL PEN-**  
12 **ALTIES AND CRIMINAL PENALTIES FOR PRO-**  
13 **VISION OF HEALTH INFORMATION TECH-**  
14 **NOLOGY AND TRAINING SERVICES.**

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

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

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

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

1           “(8) The term ‘health information technology’  
2           means hardware, software, license, right, intellectual  
3           property, equipment, or other information tech-  
4           nology (including new versions, upgrades, and  
5           connectivity) designed or provided primarily for the  
6           electronic creation, maintenance, or exchange of  
7           health information to better coordinate care or im-  
8           prove health care quality, efficiency, or research.”.

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

11           (1) in subsection (b)(3)—

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

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

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

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

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

24                           (i) by redesignating such subpara-  
25                           graph as subparagraph (I);

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

3 (iii) by striking the period at the end  
4 and inserting “; and”; and

5 (D) by adding at the end the following new  
6 subparagraph:

7 “(J) any nonmonetary remuneration (in the  
8 form of health information technology, as defined in  
9 section 1128A(i)(8), or related installation, mainte-  
10 nance, support or training services) made to a per-  
11 son by a specified entity (as defined in subsection  
12 (g)) if—

13 “(i) the provision of such remuneration is  
14 without an agreement between the parties or  
15 legal condition that—

16 “(I) limits or restricts the use of the  
17 health information technology to services  
18 provided by the physician to individuals re-  
19 ceiving services at the specified entity;

20 “(II) limits or restricts the use of the  
21 health information technology in conjunc-  
22 tion with other health information tech-  
23 nology; or

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

4                   “(ii) such remuneration is arranged for in  
5                   a written agreement that is signed by the par-  
6                   ties involved (or their representatives) and that  
7                   specifies the remuneration solicited or received  
8                   (or offered or paid) and states that the provi-  
9                   sion of such remuneration is made for the pri-  
10                  mary purpose of better coordination of care or  
11                  improvement of health quality, efficiency, or re-  
12                  search; and

13                  “(iii) the specified entity providing the re-  
14                  muneration (or a representative of such entity)  
15                  has not taken any action to disable any basic  
16                  feature of any hardware or software component  
17                  of such remuneration that would permit inter-  
18                  operability.”; and

19                  (2) by adding at the end the following new sub-  
20                  section:

21                  “(g) SPECIFIED ENTITY DEFINED.—For purposes of  
22                  subsection (b)(3)(J), the term ‘specified entity’ means an  
23                  entity that is a hospital, group practice, prescription drug  
24                  plan sponsor, a Medicare Advantage organization, or any  
25                  other such entity specified by the Secretary, considering

1 the goals and objectives of this section, as well as the goals  
2 to better coordinate the delivery of health care and to pro-  
3 mote the adoption and use of health information tech-  
4 nology.”.

5 (c) EFFECTIVE DATE AND EFFECT ON STATE  
6 LAWS.—

7 (1) EFFECTIVE DATE.—The amendments made  
8 by subsections (a) and (b) shall take effect on the  
9 date that is 120 days after the date of the enact-  
10 ment of this Act.

11 (2) PREEMPTION OF STATE LAWS.—No State  
12 (as defined in section 1101(a) of the Social Security  
13 Act (42 U.S.C. 1301(a)) for purposes of title XI of  
14 such Act) shall have in effect a State law that im-  
15 poses a criminal or civil penalty for a transaction de-  
16 scribed in section 1128A(b)(4) or section  
17 1128B(b)(3)(J) of such Act, as added by subsections  
18 (a)(1) and (b), respectively, if the conditions de-  
19 scribed in the respective provision, with respect to  
20 such transaction, are met.

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

23 (1) IN GENERAL.—The Secretary of Health and  
24 Human Services shall conduct a study to determine  
25 the impact of each of the safe harbors described in

1 paragraph (3). In particular, the study shall examine  
2 the following:

3 (A) The effectiveness of each safe harbor  
4 in increasing the adoption of health information  
5 technology.

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

8 (C) The extent to which the financial or  
9 other business relationships between providers  
10 under each safe harbor have changed as a re-  
11 sult of the safe harbor in a way that adversely  
12 affects or benefits the health care system or  
13 choices available to consumers.

14 (D) The impact of the adoption of health  
15 information technology on health care quality,  
16 cost, and access under each safe harbor.

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

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

1 (A) the safe harbor under section  
 2 1128A(b)(4) of such Act (42 U.S.C. 1320a-  
 3 7a(b)(4)), as added by subsection (a)(1); and

4 (B) the safe harbor under section  
 5 1128B(b)(3)(J) of such Act (42 U.S.C. 1320a-  
 6 7b(b)(3)(J)), as added by subsection (b).

7 **SEC. 302. EXCEPTION TO LIMITATION ON CERTAIN PHYSI-**  
 8 **CIAN REFERRALS (UNDER STARK) FOR PRO-**  
 9 **VISION OF HEALTH INFORMATION TECH-**  
 10 **NOLOGY AND TRAINING SERVICES TO**  
 11 **HEALTH CARE PROFESSIONALS.**

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

15 “(6) INFORMATION TECHNOLOGY AND TRAIN-  
 16 ING SERVICES.—

17 “(A) IN GENERAL.—Any nonmonetary re-  
 18 munerated (in the form of health information  
 19 technology or related installation, maintenance,  
 20 support or training services) made by a speci-  
 21 fied entity to a physician if—

22 “(i) the provision of such remunera-  
 23 tion is without an agreement between the  
 24 parties or legal condition that—

1                   “(I) limits or restricts the use of  
2                   the health information technology to  
3                   services provided by the physician to  
4                   individuals receiving services at the  
5                   specified entity;

6                   “(II) limits or restricts the use of  
7                   the health information technology in  
8                   conjunction with other health informa-  
9                   tion technology; or

10                   “(III) conditions the provision of  
11                   such remuneration on the referral of  
12                   patients or business to the specified  
13                   entity;

14                   “(ii) such remuneration is arranged  
15                   for in a written agreement that is signed  
16                   by the parties involved (or their represent-  
17                   atives) and that specifies the remuneration  
18                   made and states that the provision of such  
19                   remuneration is made for the primary pur-  
20                   pose of better coordination of care or im-  
21                   provement of health quality, efficiency, or  
22                   research; and

23                   “(iii) the specified entity (or a rep-  
24                   resentative of such entity) has not taken  
25                   any action to disable any basic feature of

1           any hardware or software component of  
2           such remuneration that would permit  
3           interoperability.

4           “(B) HEALTH INFORMATION TECHNOLOGY  
5           DEFINED.—For purposes of this paragraph, the  
6           term ‘health information technology’ means  
7           hardware, software, license, right, intellectual  
8           property, equipment, or other information tech-  
9           nology (including new versions, upgrades, and  
10          connectivity) designed or provided primarily for  
11          the electronic creation, maintenance, or ex-  
12          change of health information to better coordi-  
13          nate care or improve health care quality, effi-  
14          ciency, or research.

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

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

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

5           (2) PREEMPTION OF STATE LAWS.—No State  
6           (as defined in section 1101(a) of the Social Security  
7           Act (42 U.S.C. 1301(a)) for purposes of title XI of  
8           such Act) shall have in effect a State law that im-  
9           poses a criminal or civil penalty for a transaction de-  
10          scribed in section 1877(b)(6) of such Act, as added  
11          by subsection (a), if the conditions described in such  
12          section, with respect to such transaction, are met.

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

15                 (1) IN GENERAL.—The Secretary of Health and  
16                 Human Services shall conduct a study to determine  
17                 the impact of the exception under section 1877(b)(6)  
18                 of such Act (42 U.S.C. 1395nn(b)(6)), as added by  
19                 subsection (a). In particular, the study shall examine  
20                 the following:

21                         (A) The effectiveness of the exception in  
22                         increasing the adoption of health information  
23                         technology.

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

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

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

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

15 **SEC. 303. RULES OF CONSTRUCTION REGARDING USE OF**  
16 **CONSORTIA.**

17          (a) APPLICATION TO SAFE HARBOR FROM CRIMINAL  
18          PENALTIES.—Section 1128B(b)(3) of the Social Security  
19          Act (42 U.S.C. 1320a–7b(b)(3)) is amended by adding  
20          after and below subparagraph (J), as added by section  
21          301(b)(1), the following: “For purposes of subparagraph  
22          (J), nothing in such subparagraph shall be construed as  
23          preventing a specified entity, consistent with the specific  
24          requirements of such subparagraph, from forming a con-  
25          sortium composed of health care providers, payers, em-

1 ployers, and other interested entities to collectively pur-  
2 chase and donate health information technology, or from  
3 offering health care providers a choice of health informa-  
4 tion technology products in order to take into account the  
5 varying needs of such providers receiving such products.”.

6 (b) APPLICATION TO STARK EXCEPTION.—Para-  
7 graph (6) of section 1877(b) of the Social Security Act  
8 (42 U.S.C. 1395nn(b)), as added by section 302(a), is  
9 amended by adding at the end the following new subpara-  
10 graph:

11 “(D) RULE OF CONSTRUCTION.—For pur-  
12 poses of subparagraph (A), nothing in such  
13 subparagraph shall be construed as preventing  
14 a specified entity, consistent with the specific  
15 requirements of such subparagraph, from—

16 “(i) forming a consortium composed  
17 of health care providers, payers, employers,  
18 and other interested entities to collectively  
19 purchase and donate health information  
20 technology; or

21 “(ii) offering health care providers a  
22 choice of health information technology  
23 products in order to take into account the  
24 varying needs of such providers receiving  
25 such products.”.

1                   **TITLE IV—ADDITIONAL**  
2                   **PROVISIONS**

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

4           (a) **FACILITATING THE PROVISION OF TELEHEALTH**  
5 **SERVICES ACROSS STATE LINES.**—The Secretary of  
6 Health and Human Services shall, in coordination with  
7 physicians, health care practitioners, patient advocates,  
8 and representatives of States, encourage and facilitate the  
9 adoption of State reciprocity agreements for practitioner  
10 licensure in order to expedite the provision across State  
11 lines of telehealth services.

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

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

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

21          (a) **STUDY.**—The Secretary of Health and Human  
22 Services shall conduct a study to determine the feasibility,  
23 advisability, and the costs of—

24                   (1) including coverage and payment for home  
25                   health-related telehealth services as part of home

1 health services under title XVIII of the Social Secu-  
2 rity Act; and

3 (2) expanding the list of sites described in para-  
4 graph (4)(C)(ii) of section 1834(m) of the Social Se-  
5 curity Act (42 U.S.C. 1395m(m)) to include county  
6 mental health clinics or other publicly funded mental  
7 health facilities for the purpose of payment under  
8 such section for the provision of telehealth services  
9 at such clinics or facilities.

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

13 (1) Enhanced health outcomes for individuals  
14 with one or more chronic conditions.

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

22 (3) Facilitation of communication of more accu-  
23 rate clinical information between health care pro-  
24 viders.

1           (4) Closer monitoring of individuals by health  
2           care providers.

3           (5) Overall reduction in expenditures for health  
4           care items and services.

5           (6) Improved access to health care.

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

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

1 **SEC. 403. STUDY AND REPORT ON STORE AND FORWARD**  
2 **TECHNOLOGY FOR TELEHEALTH.**

3 (a) **STUDY.**—The Secretary of Health and Human  
4 Services, acting through the Director of the Office for the  
5 Advancement of Telehealth, shall conduct a study on the  
6 use of store and forward technologies (that provide for the  
7 asynchronous transmission of health care information in  
8 single or multimedia formats) in the provision of tele-  
9 health services. Such study shall include an assessment of  
10 the feasibility, advisability, and the costs of expanding the  
11 use of such technologies for use in the diagnosis and treat-  
12 ment of certain conditions.

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

20 **SEC. 404. ENSURING HEALTH CARE PROVIDERS PARTICI-**  
21 **PATING IN PHSA PROGRAMS, MEDICAID,**  
22 **SCHIP, OR THE MCH PROGRAM MAY MAIN-**  
23 **TAIN HEALTH INFORMATION IN ELECTRONIC**  
24 **FORM.**

25 Part D of title II of the Public Health Service Act,  
26 as added by section 101(a) and amended by sections 103

1 and 105, is further amended by adding at the end the  
2 following new section:

3 **“SEC. 274. ENSURING HEALTH CARE PROVIDERS MAY MAIN-**  
4 **TAIN HEALTH INFORMATION IN ELECTRONIC**  
5 **FORM.**

6 “(a) IN GENERAL.—Any health care provider that  
7 participates in a health care program that receives Federal  
8 funds under this Act, or under title V, XIX, or XXI of  
9 the Social Security Act, shall be deemed as meeting any  
10 requirement for the maintenance of data in paper form  
11 under such program (whether or not for purposes of man-  
12 agement, billing, reporting, reimbursement, or otherwise)  
13 if the required data is maintained in an electronic form.

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

18 “(c) CONSTRUCTION.—Nothing in this section shall  
19 be construed as—

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

22 “(2) preventing a State from permitting health  
23 care providers to maintain or submit data in paper  
24 form; or

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

4 **SEC. 405. ENSURING HEALTH CARE PROVIDERS PARTICI-**  
5                   **PATING IN THE MEDICARE PROGRAM MAY**  
6                   **MAINTAIN HEALTH INFORMATION IN ELEC-**  
7                   **TRONIC FORM.**

8           Section 1871 of the Social Security Act (42 U.S.C.  
9 1395hh) is amended by adding at the end the following  
10 new subsection:

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

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

20 **SEC. 406. STUDY AND REPORT ON STATE, REGIONAL, AND**  
21                   **COMMUNITY HEALTH INFORMATION EX-**  
22                   **CHANGES.**

23           (a) STUDY.—The Secretary of Health and Human  
24 Services shall conduct a study on issues related to the de-  
25 velopment, operation, and implementation of State, re-

1 gional, and community health information exchanges.  
2 Such study shall include the following, with respect to  
3 such health information exchanges:

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

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

11 (A) any impact on the coordination of  
12 health information and services across  
13 healthcare providers and other organizations  
14 relevant to health care;

15 (B) any impact on the availability of health  
16 information at the point-of-care to make timely  
17 medical decisions;

18 (C) any benefits with respect to the pro-  
19 motion of wellness, disease prevention, and  
20 chronic disease management;

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

23 (E) any impact on the widespread adoption  
24 of interoperable health information technology,  
25 including electronic health records;

1 (F) any contributions to achieving an  
2 Internet-based national health information net-  
3 work;

4 (G) any contribution of health information  
5 exchanges to consumer access and to con-  
6 sumers' use of their health information; and

7 (H) any impact on the operation of—

8 (i) the Medicaid and Medicare pro-  
9 grams;

10 (ii) the State Children's Health Insur-  
11 ance Program (SCHIP);

12 (iii) disproportionate share hospitals  
13 described in section 1923 of the Social Se-  
14 curity Act;

15 (iv) Federally-qualified health centers;

16 or

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

21 (3) Best practice models for financing,  
22 incentivizing, and sustaining such health information  
23 exchanges.

24 (4) Information identifying the common prin-  
25 ciples, policies, tools, and standards used (or pro-

1 posed) in the public and private sectors to support  
2 the development, operation, and implementation of  
3 such health information exchanges.

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

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

15 **SEC. 407. PROMOTING HEALTH INFORMATION TECH-**  
16 **NOLOGY AS A TOOL FOR CHRONIC DISEASE**  
17 **MANAGEMENT.**

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

24 (b) STRUCTURE OF PROJECT.—The project under  
25 subsection (a) shall—

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

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

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

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

1 administrative action as the Secretary determines appro-  
2 priate.

Passed the House of Representatives July 27, 2006.

Attest:

*Clerk.*



109<sup>TH</sup> CONGRESS  
2<sup>D</sup> SESSION

**H. R. 4157**

---

**AN ACT**

To promote a better health information system.