

110TH CONGRESS
1ST SESSION

H. R. 1952

To amend title XI of the Social Security Act to achieve a national health information infrastructure, and to amend the Internal Revenue Code of 1986 to increase the deduction under section 179 for the purchase of qualified health care information technology by medical care providers.

IN THE HOUSE OF REPRESENTATIVES

APRIL 19, 2007

Mr. GONZALEZ (for himself, Mr. GINGREY, Ms. VELÁZQUEZ, and Mr. GENE GREEN of Texas) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XI of the Social Security Act to achieve a national health information infrastructure, and to amend the Internal Revenue Code of 1986 to increase the deduction under section 179 for the purchase of qualified health care information technology by medical care providers.

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.**

2 This Act may be cited as “National Health Informa-
3 tion Incentive Act of 2007”.

4 **SEC. 2. FINDINGS AND PURPOSE.**

5 (a) FINDINGS.—The Congress finds as follows:

6 (1) A March 2001 Institute of Medicine
7 (“IOM”) study concludes that in order to improve
8 quality, the nation must have a national commit-
9 ment to building an information infrastructure to
10 support healthcare delivery, consumer health, quality
11 measurement and improvement, public account-
12 ability, clinical and health services research, and
13 clinical education.

14 (2) A November 2001 National Committee on
15 Vital Health Statistics study lauds the importance of
16 a national health information infrastructure to im-
17 prove patient safety, improve healthcare quality, im-
18 prove bioterrorism detection, better inform and em-
19 power healthcare consumers regarding their own
20 personal health information, and to better under-
21 stand healthcare costs.

22 (3) An October 2002 IOM report calls on the
23 federal government to take steps to encourage and
24 facilitate development in the information technology
25 infrastructure that is critical to healthcare quality
26 and safety enhancement.

1 (4) A General Accounting Office October 2003
2 report found that the benefits of an electronic
3 healthcare information system included improved
4 quality of care, reduced costs associated with medi-
5 cation errors, more accurate and complete medical
6 documentation, more accurate capture of codes and
7 charges, and improved communication among pro-
8 viders enabling them to respond more quickly to pa-
9 tients' needs.

10 (5) Other more recent studies and surveys show
11 that cultivating a national healthcare information in-
12 frastructure and improving patient care will depend
13 crucially on adoption of uniform medical data stand-
14 ards and interoperability.

15 (6) The ability of physicians to deliver patient-
16 centered care to patients, particularly those with
17 multiple chronic illnesses, will depend on having the
18 electronic systems in place at the practice level to
19 enable them to track patients by disease conditions,
20 to have access to evidence-based clinical decision
21 support tools at the point of care, to share informa-
22 tion with patients and other health care profes-
23 sionals, and to track, measure and report on the
24 quality of care provided.

1 (7) A Commonwealth Fund survey of physicians
2 found that there is a gap between physicians' sup-
3 port for and willingness to provide such patient-cen-
4 tered services and having the electronic systems in
5 place to enable them to do, with the costs of acquir-
6 ing and maintaining such systems being identified as
7 a major barrier.

8 (8) Acquisition costs, physician and staff time
9 required to transition from paper-based offices to
10 electronic health systems, and the lack of industry
11 standards on interoperability are the principle bar-
12 riers to creating a national health information infra-
13 structure.

14 (9) The success of a national health informa-
15 tion infrastructure depends on the widespread use
16 and acceptance of electronic health records and
17 other health information technologies in physician
18 offices.

19 (b) PURPOSES.—The purposes of this Act are as fol-
20 lows:

21 (1) To create incentives that encourage physi-
22 cians and other health professionals to adopt inter-
23 operable electronic health records, electronic pre-
24 scribing systems, evidence-based clinical decision
25 tools, remote monitoring, patient registries, secure

1 email, and other health information technology as a
2 key component of a national health care information
3 infrastructure in the United States to ensure the
4 rapid flow of secure, private and digitized informa-
5 tion relevant to all facets of patient care.

6 (2) To do so in a voluntary manner that does
7 not become an unfunded mandate on small physician
8 practices.

9 (3) To do so in a manner that does not com-
10 promise the medical care provider's ability to make
11 patient care decisions based solely on his or her clin-
12 ical expertise and experience, and what the provider
13 and patient concludes is the best for a particular pa-
14 tient based upon scientific evidence and knowledge
15 of the patient's medical history.

16 **SEC. 3. OFFICE OF THE NATIONAL COORDINATOR FOR**
17 **HEALTH INFORMATION TECHNOLOGY.**

18 (a) ESTABLISHMENT.—There is established within
19 the Office of the Secretary of Health and Human Services
20 an Office of the National Coordinator for Health Informa-
21 tion Technology. The Office shall be headed by a National
22 Coordinator appointed by the President, in consultation
23 with the Secretary of Health and Human Services. The
24 National Coordinator shall report directly to the Sec-
25 retary.

1 (b) RESOURCES.—The President shall make available
2 to the Office of the National Coordinator for Health Infor-
3 mation Technology the resources, both financial and oth-
4 erwise, necessary to enable the National Coordinator to
5 carry out the purposes of, and perform the duties and re-
6 sponsibilities of, the Office.

7 **SEC. 4. BUILDING THE NATIONAL HEALTH INFORMATION**
8 **INFRASTRUCTURE.**

9 Title XI of the Social Security Act (42 U.S.C. 1301
10 et seq.) is amended by adding at the end the following
11 part:

12 “PART D—BUILDING THE NATIONAL HEALTH
13 INFORMATION INFRASTRUCTURE
14 “FINANCIAL INCENTIVE TO SMALL MEDICAL CARE PRO-
15 VIDERS AND ENTITIES TO IMPLEMENT A NATIONAL
16 HEALTH INFORMATION INFRASTRUCTURE

17 “SEC. 1181. (a) IN GENERAL.—The Secretary shall
18 include additional Medicare payment incentives to assure
19 small medical care providers have the capability to move
20 toward a national health care information infrastructure
21 by acquiring electronic health record systems and other
22 health information technologies.

23 “(b) CONDITIONS FOR QUALIFICATION.—As a condi-
24 tion of qualifying for financial incentives described in this
25 section, the Secretary shall grant the use of financial in-

1 centives to assure that such technologies are consistent
2 with the goals of creation of a national health information
3 infrastructure, such as—

4 “(1) voluntary participation in studies or dem-
5 onstration projects to evaluate the use of such sys-
6 tems to measure and report quality data based on
7 accepted clinical performance measures;

8 “(2) voluntary participation in studies to dem-
9 onstrate the impact of such technologies on improv-
10 ing patient care, reducing costs and increasing effi-
11 ciencies; and

12 “(3) voluntary participation in studies and dem-
13 onstration projects on providing patient-centered
14 care coordinated by a patient’s personal physician
15 (as defined by the Institute of Medicine), using elec-
16 tronic systems that enable and facilitate care coordi-
17 nation and sharing of information among the physi-
18 cian and other treating health care professionals,
19 family caregivers, and the patient.

20 “(c) ADDITIONAL MEDICARE PAYMENT TO SMALL
21 MEDICAL CARE PROVIDERS AND ENTITIES FOR EXPEND-
22 ITURES RELATING TO THE IMPLEMENTATION OF PRAC-
23 TICE-BASED ELECTRONIC SYSTEMS THAT WILL SERVE
24 AS THE FOUNDATION FOR A NATIONAL HEALTH INFOR-
25 MATION INFRASTRUCTURE.—

1 “(1) IN GENERAL.—The Secretary shall provide
2 for additional payment to medical care providers in
3 small practice settings, including physicians and oth-
4 ers in clinical practice, for the purpose of assisting
5 such entities to acquire and adopt patient registries,
6 evidence-based clinical decision support tools at the
7 point of care, electronic health records, secure email,
8 and other health information technologies defined by
9 the Secretary as a key component of a national
10 health care information infrastructure.

11 “(2) TYPES OF REIMBURSEMENT INCEN-
12 TIVES.—In developing the reimbursement incentives
13 described in paragraph (1), the Secretary shall con-
14 sider inclusion of one or more of the following types
15 of incentives:

16 “(A) Adds-ons to payments for evaluation
17 and management services.

18 “(B) Care management fees that include
19 an allowance for the costs associated with ac-
20 quiring the electronic systems associated with
21 providing coordinated and patient-centered care
22 to beneficiaries, especially those with multiple
23 chronic illnesses, as determined by the Sec-
24 retary and that is included in the top 5 percent
25 of claims (determined on the basis of cost).

1 “(C) Payments for structured e-mail
2 consults and other technologies that will facili-
3 tate care coordination that are separately iden-
4 tifiable medical services from other evaluation
5 and management services.

6 “(D) Any other method deemed appro-
7 priate by the Secretary to encourage participa-
8 tion.

9 “(3) AMOUNT OF REIMBURSEMENT.—The
10 amount of reimbursement made to small medical
11 care providers and entities to implement a national
12 health care information infrastructure shall be in a
13 manner determined by the Secretary that takes into
14 account the costs of implementation, training, and
15 complying with applicable standards. Such reim-
16 bursement amounts shall be calculated on a sliding
17 scale, in a manner determined by the Secretary, to
18 reward qualifying practices using more functional
19 and comprehensive health information systems that
20 meet the certification guidelines under paragraph
21 (4) based on the following weighted-structure:

22 “(A) BASIC.—The maintenance of patient
23 registries for the purpose of identifying and fol-
24 lowing up with at-risk patients and for the pro-
25 vision of educational resources to patients.

1 “(B) INTERMEDIATE.—In addition to com-
2 plying with subparagraph (A), the use of three
3 or more of the following:

4 “(i) An electronic systems to maintain
5 patient records (EHRs).

6 “(ii) Clinical-decision support tools.

7 “(iii) Electronic order for prescrip-
8 tions and lab tests (e-prescribing).

9 “(iv) Patient reminders.

10 “(v) E-consults (communication be-
11 tween patient-physician or other provider)
12 when an identifiable medical service is pro-
13 vided.

14 “(vi) Managing patients with multiple
15 chronic illnesses.

16 “(C) ADVANCED.—In addition to com-
17 plying with subparagraphs (A) and (B), the use
18 by a practice of an electronic system that—

19 “(i) is interconnected and is interoper-
20 able with other electronic systems;

21 “(ii) uses nationally accepted medical
22 code sets; and

23 “(iii) can automatically send, receive,
24 and integrate data, such as lab results and

1 medical histories, from other organizations’
2 systems.

3 “(4) CERTIFICATION OF TECHNOLOGY.—The
4 technology used under paragraph (3) must meet
5 such guidelines for functionality as may be developed
6 by the Secretary. In the case of technology for elec-
7 tronic health records (EHRs), technology that has
8 been certified by the Certification Commission for
9 Healthcare Information Technology (CCHIT) shall
10 be considered as having met such guidelines.

11 “(5) EXEMPTION FROM BUDGET NEUTRALITY
12 UNDER THE PHYSICIAN FEE SCHEDULE.—Any in-
13 creased expenditures pursuant to this section shall
14 be treated as additional allowed expenditures for
15 purposes of computing any update under section
16 1848(d).

17 “(d) SMALL MEDICARE CARE PROVIDER DE-
18 FINED.—In this part, the term ‘small medical care pro-
19 vider’ means a medical care provider (as defined in section
20 179(e)(2)(B) of the Internal Revenue Code of 1986) that
21 has an average of 10 or fewer full-time equivalent employ-
22 ees during the period involved.

1 “OPTIONAL FINANCIAL INCENTIVES TO SMALL MEDICAL
2 CARE PROVIDERS AND ENTITIES TO IMPLEMENT A
3 NATIONAL HEALTH INFORMATION INFRASTRUCTURE

4 “SEC. 1182. (a) IN GENERAL.—The Secretary may
5 utilize any, all, or a combination of financial incentives
6 thereof, to assure small medical care providers have the
7 capability to move toward a national health care informa-
8 tion infrastructure by acquiring electronic health record
9 systems and other health information technologies that
10 meet the standards adopted or modified by the Secretary.

11 “(b) CONDITIONS FOR QUALIFICATION.—As a condi-
12 tion of qualifying for financial incentives described in this
13 section, the Secretary shall grant the use of financial in-
14 centives to assure that such technologies are consistent
15 with the goals of creation of a national health information
16 infrastructure, such as—

17 “(1) voluntary participation in studies or dem-
18 onstration projects to evaluate the use of such sys-
19 tems to measure and report quality data based on
20 accepted clinical performance measures;

21 “(2) voluntary participation in studies to dem-
22 onstrate the impact of such technologies on improv-
23 ing patient care, reducing costs and increasing effi-
24 ciencies; and

1 “(3) voluntary participation in studies and dem-
2 onstration projects on providing patient-centered
3 care coordinated by a patient’s personal physician
4 (as defined by the Institute of Medicine), using elec-
5 tronic systems that enable and facilitate care coordi-
6 nation and sharing of information among the physi-
7 cian and other treating health care professionals,
8 family caregivers, and the patient.

9 “(c) GRANTS TO SMALL MEDICAL CARE PROVIDERS
10 AND ENTITIES FOR EXPENDITURES RELATING TO THE
11 IMPLEMENTATION OF A NATIONAL HEALTH INFORMA-
12 TION INFRASTRUCTURE.—

13 “(1) IN GENERAL.—The Secretary is authorized
14 to make grants to small medical care providers, in-
15 cluding physicians and others in clinical practice, for
16 the purpose of assisting such entities to acquire and
17 adopt patient registries, evidence-based clinical deci-
18 sion support tools at the point of care, electronic
19 health records, secure email, and other health infor-
20 mation technologies defined by the Secretary as a
21 key component of a national health care information
22 infrastructure.

23 “(2) AMOUNT OF GRANT.—The grant amount
24 made to small medical care providers and entities to
25 implement a national health care information infra-

1 structure shall be in a manner determined by the
2 Secretary that takes into account the costs of imple-
3 mentation, training, and complying with applicable
4 standards.

5 “(3) APPLICATION.—No grant may be made
6 under this subsection except pursuant to a grant ap-
7 plication that is submitted in a time, manner, and
8 form approved by the Secretary.

9 “(4) AUTHORIZATION OF APPROPRIATIONS.—
10 There are authorized to be appropriated to carry out
11 this subsection such sums as may be necessary for
12 each fiscal year.

13 “(d) REVOLVING LOANS TO SMALL MEDICAL CARE
14 PROVIDERS AND ENTITIES FOR EXPENDITURES RELAT-
15 ING TO THE IMPLEMENTATION OF A NATIONAL HEALTH
16 INFORMATION INFRASTRUCTURE.—

17 “(1) IN GENERAL.—The Secretary is authorized
18 to make and guarantee loans to small medical care
19 providers, including physicians and others in clinical
20 practice, for the purpose of assisting such entities to
21 acquire and adopt patient registries, evidence-based
22 clinical decision support tools at the point of care,
23 electronic health records, secure email, and other
24 health information technologies defined by the Sec-

1 retary as a key component of a national health care
2 information infrastructure.

3 “(2) AMOUNT OF LOAN.—The loan amount
4 made to small medical care providers and entities to
5 implement a national health care information infra-
6 structure shall be in a manner determined by the
7 Secretary that takes into account the costs of imple-
8 mentation, training, and complying with standards.

9 “(3) APPLICATION.—No loan may be made
10 under this subsection except pursuant to a loan ap-
11 plication that is submitted in a time, manner, and
12 form approved by the Secretary.

13 “(4) AUTHORIZATION OF APPROPRIATIONS.—
14 There are authorized to be appropriated to carry out
15 this subsection such sums as may be necessary for
16 each fiscal year.”.

17 **SEC. 5. ELECTION TO EXPENSE QUALIFIED HEALTH CARE**
18 **INFORMATION TECHNOLOGY.**

19 (a) IN GENERAL.—Section 179 of the Internal Rev-
20 enue Code of 1986 (relating to election to expense certain
21 depreciable assets) is amended by adding at the end the
22 following new subsection:

23 “(e) HEALTH CARE INFORMATION TECHNOLOGY.—

24 “(1) IN GENERAL.—In the case of qualified
25 health care information technology purchased by a

1 medical care provider and placed in service during a
2 taxable year—

3 “(A) subsection (b)(1) shall be applied by
4 substituting ‘\$250,000’ for ‘\$100,000’,

5 “(B) subsection (b)(2) shall be applied by
6 substituting ‘\$600,000’ for ‘\$400,000’, and

7 “(C) subsection (b)(5)(A) shall be applied
8 by substituting ‘\$250,000 and \$600,000’ for
9 ‘\$100,000 and \$400,000’.

10 “(2) DEFINITIONS.—For purposes of this sub-
11 section—

12 “(A) QUALIFIED HEALTH CARE INFORMA-
13 TION TECHNOLOGY.—The term ‘qualified health
14 care information technology’ means section 179
15 property which—

16 “(i) meets such guidelines for
17 functionality as may be developed by the
18 Secretary of Health and Human Services
19 under section 1181(c)(4) of the Social Se-
20 curity Act, and

21 “(ii) is used primarily for the elec-
22 tronic creation, maintenance, and exchange
23 of medical care information to improve the
24 quality or efficiency of medical care.

1 “(B) MEDICAL CARE PROVIDER.—The
2 term ‘medical care provider’ means any person
3 engaged in the trade or business of providing
4 medical care.

5 “(C) MEDICAL CARE.—The term ‘medical
6 care’ has the meaning given such term by sec-
7 tion 213(d).”.

8 (b) EFFECTIVE DATE.—The amendment made by
9 this section shall apply to property placed in service after
10 December 31, 2006.

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