The American Recovery and Reinvestment Act of 2009
HIMSS Legislative Overview, Policy Implications, and Healthcare Ramifications
March 10, 2009

On February 17, 2009, President Barack Obama signed into law the American Recovery and Reinvestment Act of 2009, H.R. 1. The legislation is designed to develop a solid health information infrastructure for healthcare and stimulating the economy through new investment and job growth. This document provides HIMSS members with a detailed analysis of the legislation, including an overview of the policy and industry ramifications, and HIMSS positions, if any. Also included in the document are due dates for legislative provisions, as established through the legislation. The third column in the document includes the due dates, while the corresponding legislative text is highlighted in yellow. As an additional tool for our members, a summary document of the legislation on the legislation is available online.

The Act's language is complex, and HIMSS will continue to refine this document. This analysis is for informational purposes only, and none of its content should be construed as legal advice. HIMSS members are strongly encouraged to independently consult with legal counsel. If you have any questions regarding this analysis, or HIMSS government relations activities, please contact us. Visit our website for the latest developments.

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DIVISION A – APPROPRIATIONS		
Distance Learning, Telemedicine, and Broadband Program Account		
$2,500,000 for distance learning, telemedicine, and broadband programs through broadband loans and loan guarantees, as authorized by the Rural Electrification Act of 1936 (7 U.S.C. 901 et seq.) and for grants (including for technical assistance),	**Distance Learning and Telemedicine Services:** HIMSS supports this provision as it is consistent with HIMSS' recommendations for the federal government to provide additional financial support for telehealth services as detailed in HIMSS' December 2008 report, *Enabling Healthcare Reform Using Information Technology*. HIMSS trusts that the Department of Agriculture will work with the Federal Communications Committee (FCC) and the Office of the National Coordinator for Health IT (ONC) to ensure that broadband activities are coordinated with existing programs bringing broadband technologies to rural and underserved healthcare settings.	Upon Enactment

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National Telecommunications and Information Administration		
$4,700,000,000 for the Broadband Technologies Opportunities Program within the National Telecommunications and Information Administration. Funds provided under this heading, not less than $4,350,000,000 shall be expended pursuant to division B of this Act, of which: not less than $200,000,000 shall be available for competitive grants for expanding public computer center capacity, including at community colleges and public libraries; not less than $250,000,000 shall be available for competitive grants for innovative programs to encourage sustainable adoption of broadband service; and $10,000,000 shall be transferred to ``Department of Commerce, Office of Inspector General'' for the purposes of audits and oversight of funds provided under this heading and such funds shall remain available until expended: Provided further, That of the funds provided under this heading, up to $350,000,000 may be expended pursuant to Public Law 110-385 (47 U.S.C. 1301 note) and for the purposes of developing and maintaining a broadband inventory map pursuant to division B of this Act: Provided further, That of the funds provided under this heading, amounts deemed necessary and appropriate by the Secretary of Commerce, in consultation with the Federal Communications Commission (FCC), may be transferred to the FCC for the purposes of developing a national broadband plan or for carrying out any other FCC responsibilities pursuant to division B of this Act, and only if the Committees on Appropriations of the House and the Senate are notified not less than 15 days in advance of the transfer of such funds: Provided further, That not more than 3 percent of funds provided under this heading may be used for administrative costs, and this limitation shall apply to funds which may be transferred to the FCC.	**Broadband Technology Opportunities Program:** HIMSS supports this provision as it is consistent with HIMSS' recommendations for the federal government to provide additional financial support for telehealth services as detailed in HIMSS' December 2008 report, *Enabling Healthcare Reform Using Information Technology*.	Upon Enactment Due Notice
Title VII – INTERIOR , ENVIRONMENT, AND RELATED AGENCIES		
Department of Health and Human Services, Indian Health Services		
$85,000,000 is for health IT and the amount may be used for both telehealth	**Health IT and Telehealth Services for the Indian Health Service:** HIMSS supports this provision that authorizes and	Upon Enactment

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services development and related infrastructure requirements that are typically funding through the "Indian Health Facilities". Health IT funds provided within this title shall be allocated at the discretion of the Director of the Indian Health Service. (Retained)	appropriates funding for health IT and telehealth services for the Indian Health Services (IHS). In three instances over the past five years, the IHS has demonstrated a level of excellence in the deployment of EHRs that has been recognized by the HIMSS Davies Award Review Panel. Most recently, the Cherokee Indian Hospital Authority received the 2008 Davies Award for excellence in the use of electronic health data. This hospital is the primary medical home and public health provider for an active user population of over 10,000 members of the Eastern Band of the Cherokee Indians. Clinical use includes a hospital, multiple primary care clinics, supportive services to include laboratory and radiology as well as substance abuse and mental health programs. In addition, this level of excellence throughout the Indian Health Service will further the cause of interoperable, secure healthcare data exchange. The Indian Health Service is engaged in the Federal Health Architecture Initiative, which is providing cross-agency direction for interoperability specifications that are consistent with the HITSP process.	
Title VIII- DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES		
Health Resources and Services Administration		
$1,500,000,000 shall be made available for grants for construction, renovation, and equipment for health centers receiving operating grants under Section 330 of the Public Health Service Act, notwithstanding the limitation.[1]	**Equipment for Health Centers:** HIMSS supports this provision to provide funding to assist health centers in obtaining equipments and hopes that the funds will be applied	Upon Enactment

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	for health IT in efforts to achieve interoperable, secure healthcare data exchange. Section 330 of the Public Health Service Act defines the term "health center" as an entity that serves a population that is medically underserved, or a special medically underserved population comprised of migratory or seasonal agricultural workers, the homeless, and residents of public housing by providing either through staff or supporting resources required primary care services or additional health services for the adequate support of primary health services.	
Agency for Healthcare Research and Quality		
$1,100,000,000 for comparative effectiveness research, and within the total, $300,000,000 shall be administered by the Agency for Healthcare Research and Quality (AHRQ), $400,000,000 shall be transferred to the National Institutes of Health (NIH), and $400,000,000 shall be allocated at the discretion of the Secretary of Health and Human Services.	**Clinical Comparative Effectiveness Research:** HIMSS supports this provision concerning comparative clinical effectiveness research. HIMSS looks forward to working with AHRQ and the National Institutes of Health (NIH) to further expand national efforts to improve upon comparative effectiveness activities that are consistent with efforts being undertaken by the private sector effort called Integrating the Healthcare Enterprise (IHE). Helping care-givers and patients see beyond the preconception that "the newest treatment is best", is at the foundation of the need to conduct scientific research to determine actual comparative clinical effectiveness of medical options. Interest in credible clinical data as a source for healthcare decision-makers in evidenced-based medicine has been gaining support among policy-makers and healthcare practitioners. Recent legislative overhauls to the Medicare drug benefits, as well as a need to examine the effectiveness of medical procedures, has increased the interest in clinical	

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	effectiveness research.	
Office of the Secretary, Office of the National Coordinator for Health Information Technology		
$2,000,000,000 for the Office of the National Coordinator for Health Information Technology to carry out title XIII of this Act, to remain available until expended: *Provided*, That of such amount, the Secretary of Health and Human Services shall transfer $20,000,000 to the Director of the National Institute of Standards and Technology in the Department of Commerce for continued work on advancing health care information enterprise integration through activities such as technical standards analysis and establishment of conformance testing infrastructure, so long as such activities are coordinated with the Office of the National Coordinator for Health Information Technology: *Provided further*, That $300,000,000 is to support regional or sub-national efforts toward health information exchange: *Provided further*, That 0.25 percent of the funds provided in this paragraph may be used for administration of such funds: *Provided further*, That funds available under this heading shall become available for obligation only upon submission of an annual operating plan by the Secretary to the Committees on Appropriations of the House of Representatives and the Senate: *Provided further*, That the fiscal year 2009 operating plan shall be provided not later than 90 days after enactment of this Act and that subsequent annual operating plans shall be provided not later than November 1 of each year: *Provided further*, That these operating plans shall describe how expenditures are aligned with the specific objectives, milestones, and metrics of the Federal Health Information Technology Strategic Plan, including any subsequent updates to the Plan; the allocation of resources within the Department of Health and Human Services and other Federal agencies; and the identification of programs and activities that are supported: *Provided further*, That the Secretary shall provide to the Committees on Appropriations of the House of Representatives and the Senate a report on the actual obligations, expenditures, and unobligated balances for each major set of activities not later than November 1, 2009, and every 6 months thereafter as long as funding provided under this heading is available for obligation or expenditure.	**Office of the National Coordinator:** HIMSS supports these provisions to authorize and appropriate funding for the Office of the National Coordinator (ONC). The Congressional Budget Office (CBO) projects that of the $2 billion that is authorized and appropriated for the ONC, that $300 million will be spent in fiscal year 2009, $1.28 billion in fiscal year 2010, $360 million in fiscal year 2011, and $40 million in fiscal year 2012. **National Institute of Standards and Technology:** HIMSS supports these provisions to authorize and appropriate funding to the National Institute of Standards and Technology (NIST) and strongly encourages NIST to continue its 3-year relationship with the Healthcare Information Technology Standards Panel (HITSP), IHE, the Certification Commission for Healthcare Information Technology (CCHIT), and MITRE in efforts concerning the standards testing and harmonization and the certification of health IT products. HIMSS believes that funding should be spent to achieve comparable levels of health IT functionality within the federal and private sectors to include hospitals, public health departments, and ambulatory physician practices.	Upon Enactment NLT 05/18/2009 and yearly thereafter by 11/09 NLT 11/01/2009 and every 6 months thereafter

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Related Agencies, Social Security Administration		
$500,000,000 is provided for processing disability and retirement workloads, including information technology acquisitions and research in support of such activities. These additional funds will allow SSA to process a growing workload of claims in a timely manner and to accelerate activities to reduce the backlog of disability claims. As the largest repository of electronic medical images in the world, SSA has a vital interest in exploring how health information technology can be integrated into the disability process through the widespread adoption of electronic medical records. The funds provided for agency operations therefore include resources for SSA health information technology research and activities to facilitate the adoption of electronic medical records in disability claims.	**Health Information Technology and the Social Security Administration:** HIMSS supports this provision and activities by the SSA to further improve the process by which clinicians can provide electronic disabilities claims submissions. We are encouraged by the willingness of the SSA to actively engage with providers and EHR manufacturers.	Upon Enactment
Title XXX- HEALTH INFORMATION TECHNOLOGY AND QUALITY **Subtitle A – Promotion of Health Information Technology** **Part I – Improving Healthcare Quality, Safety and Efficiency**		
Section 3001 – Office of the National Coordinator		
`(a) Establishment- There is established within the Department of Health and Human Services an Office of the National Coordinator for Health Information Technology (referred to in this section as the `Office'). The Office shall be headed by a National Coordinator who shall be appointed by the Secretary and shall report directly to the Secretary. `(b) Purpose- The National Coordinator shall perform the duties under subsection (c) in a manner consistent with the development of a nationwide health information technology infrastructure that allows for the electronic use and exchange of information and that-- `(1) ensures that each patient's health information is secure and protected, in accordance with applicable law; `(2) improves health care quality, reduces medical errors, reduces health	**Office of the National Coordinator**: As included in HIMSS' Government Initiatives Principles and *"Enabling Healthcare Reform Using Information Technology"*, HIMSS supports these provisions and applauds the codification of a senior level health IT position within the administration, through the establishment of the ONC. The purpose of the Office of the National Coordinator is to achieve a nationwide health IT infrastructure that allows for the electronic use & exchange of information. To achieve this purpose, the National Coordinator must address several items: 1. Ensure that each patient's health information is secure and protected;	

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disparities, and advances the delivery of patient-centered medical care; `(3) reduces health care costs resulting from inefficiency, medical errors, inappropriate care, duplicative care, and incomplete information; `(4) provides appropriate information to help guide medical decisions at the time and place of care; `(5) ensures the inclusion of meaningful public input in such development of such infrastructure; `(6) improves the coordination of care and information among hospitals, laboratories, physician offices, and other entities through an effective infrastructure for the secure and authorized exchange of health care information; `(7) improves public health activities and facilitates the early identification and rapid response to public health threats and emergencies, including bioterror events and infectious disease outbreaks; `(8) facilitates health and clinical research and health care quality; `(9) promotes early detection, prevention, and management of chronic diseases; `(10) promotes a more effective marketplace, greater competition, greater systems analysis, increased consumer choice, and improved outcomes in health care services; and `(11) improves efforts to reduce health disparities. `(c) Duties of the National Coordinator- `(1) STANDARDS- The National Coordinator shall-- `(A) review and determine whether to endorse each standard, implementation specification, and certification criterion for the electronic exchange and use of health information that is recommended by the HIT Standards Committee under section 3003 for purposes of adoption under section 3004; `(B) make such determinations under subparagraph (A), and report to the Secretary such determinations, not later than 45 days after the date the recommendation is received by the Coordinator; and `(C) review Federal health information technology investments to ensure that Federal health information technology programs are	2. Improves the quality of care, reduces medical errors, reduces health disparities, and advances the delivery of patient-centric medical care; 3. Reduces healthcare costs resulting from inefficiencies, errors, inappropriate & duplicative care, and missing information; 4. provides appropriate information at the point-of-care; 5. Ensures meaningful public input in the development of the NHIN; 6. Improves the coordination of care and information among healthcare settings through an effective infrastructure for the secure and authorized e-exchange of health information; 7. Improves public health services by facilitating the early identification and rapid response to public health threats and emergencies, including bioterror events and infectious disease outbreaks; 8. facilitates health and clinical research and health care quality; 9. promotes early detection, prevention, and management of chronic diseases; 10. promotes a more effective marketplace, greater competition, greater systems analysis, increased consumer choice, and improved outcomes in health care services; and, 11. Improves efforts to reduce health disparaties. To achieve this purpose, the National Coordinator performs several duties: 1. Within 45 days of receipt, make the decision about whether or not to accept the recommendations of the HIT Standards Committee (see section 3003); 2. Review the federal government's investments in health IT to ensure they are meeting the objectives of	Due notice

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meeting the objectives of the strategic plan published under paragraph (3). `(2) HIT POLICY COORDINATION- `(A) IN GENERAL- The National Coordinator shall coordinate health information technology policy and programs of the Department with those of other relevant executive branch agencies with a goal of avoiding duplication of efforts and of helping to ensure that each agency undertakes health information technology activities primarily within the areas of its greatest expertise and technical capability and in a manner towards a coordinated national goal. `(B) HIT POLICY AND STANDARDS COMMITTEES- The National Coordinator shall be a leading member in the establishment and operations of the HIT Policy Committee and the HIT Standards Committee and shall serve as a liaison among those two Committees and the Federal Government. `(3) STRATEGIC PLAN- `(A) IN GENERAL- The National Coordinator shall, in consultation with other appropriate Federal agencies (including the National Institute of Standards and Technology), update the Federal Health IT Strategic Plan (developed as of June 3, 2008) to include specific objectives, milestones, and metrics with respect to the following: `(i) The electronic exchange and use of health information and the enterprise integration of such information. `(ii) The utilization of an electronic health record for each person in the United States by 2014. `(iii) The incorporation of privacy and security protections for the electronic exchange of an individual's individually identifiable health information. `(iv) Ensuring security methods to ensure appropriate authorization and electronic authentication of health information and specifying technologies or methodologies for rendering health information unusable, unreadable, or	the National Coordinator's strategic plan; 3. Coordinate health IT policy within the Department of HHS, with the goals of avoiding duplicative efforts, ensuring each HHS agency focuses its health IT activities within its core competency, and working towards an NHIN; 4. Serve as a leading members of both the HIT Standards and Policy Committees, and serve as the liaison between the Committees and the federal government; 5. Update the federal health IT strategic plan (first published in July, 2008). The plan must have specific milestones, objectives, and metrics for: e-exchange & use of health information and the enterprise integration of such information; each person utilizing an EHR by 2014; ensuring private and secure health information; a framework for coordination among relevant groups; foster the public's understanding of health IT; strategies to achieve the purpose of the National Coordinator's position; and, specific plans for ensuring populations with unique needs (such as children) are included in the technology design. 6. Maintain a website the ensures transparency in the promotion of an NHIN. 7. In coordination with NIST, recognize a program for the voluntary certification of health IT. Within 12 months of the enactment of ARRA, the National Coordinator must do two things. First, the National Coordinator must submit a report on additional funding to appropriate House and Senate Committees. The report is to identify the additional funding necessary for standards, implementation specs, and certification to realize an NHIN. Also, if necessary, in the report, the National Coordinator is also to include funding requirements to ensure full	Background date

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indecipherable. `(v) Specifying a framework for coordination and flow of recommendations and policies under this subtitle among the Secretary, the National Coordinator, the HIT Policy Committee, the HIT Standards Committee, and other health information exchanges and other relevant entities. `(vi) Methods to foster the public understanding of health information technology. `(vii) Strategies to enhance the use of health information technology in improving the quality of health care, reducing medical errors, reducing health disparities, improving public health, increasing prevention and coordination with community resources, and improving the continuity of care among health care settings. `(viii) Specific plans for ensuring that populations with unique needs, such as children, are appropriately addressed in the technology design, as appropriate, which may include technology that automates enrollment and retention for eligible individuals. `(B) COLLABORATION- The strategic plan shall be updated through collaboration of public and private entities. `(C) MEASURABLE OUTCOME GOALS- The strategic plan update shall include measurable outcome goals. `(D) PUBLICATION- The National Coordinator shall republish the strategic plan, including all updates. `(4) WEBSITE- The National Coordinator shall maintain and frequently update an Internet website on which there is posted information on the work, schedules, reports, recommendations, and other information to ensure transparency in promotion of a nationwide health information technology infrastructure. `(5) CERTIFICATION- `(A) IN GENERAL- The National Coordinator, in consultation with the Director of the National Institute of Standards and Technology, shall keep or recognize a program or programs for	participation of all relevant stakeholders. Second, the National Coordinator must appoint a Chief Privacy Officer. The National Coordinator must also publish a report on lessons learned from major public and private healthcare systems who have already implemented health IT. This report is to include an assessment as to whether or not the lessons learned are applicable to, and useable by, other healthcare providers. There is no deadline assigned by Congress for this report. Also, the National Coordinator must publish an assessment of the impact of health IT in communities with health disparities and areas with high levels of un/under-insured, and medically underserved consumers. The report must identify practices to increase adoption of health IT and how health IT can reduce and better manage chronic diseases. The National Coordinator must publish evidence on the benefits and costs of the use and e-exchange of health IT – and, to whom these costs and benefits accrue. Finally, each year the National Coordinator is to publish the resources required to achieve the goal of each person living in the US to have an EHR by 2014, Congress granted the National Coordinator the ability to provide financial assistance to consumer groups and other non-profits to defray the costs of participating in the National Technology Transfer Act. The Act requires that all federal agencies use standards developed by voluntary consensus standards bodies instead of government-unique standards wherever possible. And, Congress directed the National Coordinator to establish a governance mechanism for the NHIN.	

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the voluntary certification of health information technology as being in compliance with applicable certification criteria adopted under this subtitle. Such program shall include, as appropriate, testing of the technology in accordance with section 13201(b) of the Health Information Technology for Economic and Clinical Health Act. `(B) CERTIFICATION CRITERIA DESCRIBED- In this title, the term `certification criteria' means, with respect to standards and implementation specifications for health information technology, criteria to establish that the technology meets such standards and implementation specifications. `(6) REPORTS AND PUBLICATIONS- `(A) REPORT ON ADDITIONAL FUNDING OR AUTHORITY NEEDED- Not later than 12 months after the date of the enactment of this title, the National Coordinator shall submit to the appropriate committees of jurisdiction of the House of Representatives and the Senate a report on any additional funding or authority the Coordinator or the HIT Policy Committee or HIT Standards Committee requires to evaluate and develop standards, implementation specifications, and certification criteria, or to achieve full participation of stakeholders in the adoption of a nationwide health information technology infrastructure that allows for the electronic use and exchange of health information. `(B) IMPLEMENTATION REPORT- The National Coordinator shall prepare a report that identifies lessons learned from major public and private health care systems in their implementation of health information technology, including information on whether the technologies and practices developed by such systems may be applicable to and usable in whole or in part by other health care providers. `(C) ASSESSMENT OF IMPACT OF HIT ON COMMUNITIES WITH HEALTH DISPARITIES AND UNINSURED, UNDERINSURED, AND MEDICALLY UNDERSERVED AREAS- The National Coordinator shall assess and publish the	**Certification:** HIMSS recommends NIST recognize CCHIT for the voluntary certification of health IT and utilize the relationship with IHE and MITRE to continue trusted and tested work concerning the certification of health IT. CCHIT functions as a recognized certification body (RCB) for EHRs and their networks. To date, CCHIT has certified more than 160 EHR products, representing 50% of all vendors in the market and 75% of the overall EHR market to-date. CCHIT has helped streamline the EHR market by serving as a trusted source to guide providers when adopting health IT products. CCHIT has also aided in fostering interoperability among products through implementation of its standards-based criteria. **Lessons Learned & Benefits/Costs:** HIMSS notes that the HIMSS Davies Award of Excellence has been recognizing healthcare organizations, ambulatory practices, public health entities, and community health organizations for excellence in the implementation and use of electronic health records. This large database has first-person case studies of what worked and didn't work, the successes, and lessons learned of EHR implementation, use, and return on investment. **Chief Privacy Officer**: HIMSS supports these provisions, and expresses our strong interest in learning how the Chief Privacy Officer will interact with existing HHS privacy and security activities, to include the Office of the Inspector General, the Centers for Medicare and Medicaid Services, and the Office for Civil Rights.	NLT 02/17/2010

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impact of health information technology in communities with health disparities and in areas with a high proportion of individuals who are uninsured, underinsured, and medically underserved individuals (including urban and rural areas) and identify practices to increase the adoption of such technology by health care providers in such communities, and the use of health information technology to reduce and better manage chronic diseases. `(D) EVALUATION OF BENEFITS AND COSTS OF THE ELECTRONIC USE AND EXCHANGE OF HEALTH INFORMATION- The National Coordinator shall evaluate and publish evidence on the benefits and costs of the electronic use and exchange of health information and assess to whom these benefits and costs accrue. `(E) RESOURCE REQUIREMENTS- The National Coordinator shall estimate and publish resources required annually to reach the goal of utilization of an electronic health record for each person in the United States by 2014, including-- `(i) the required level of Federal funding; `(ii) expectations for regional, State, and private investment; `(iii) the expected contributions by volunteers to activities for the utilization of such records; and `(iv) the resources needed to establish a health information technology workforce sufficient to support this effort (including education programs in medical informatics and health information management). `(7) ASSISTANCE- The National Coordinator may provide financial assistance to consumer advocacy groups and not-for-profit entities that work in the public interest for purposes of defraying the cost to such groups and entities to participate under, whether in whole or in part, the National Technology Transfer Act of 1995 (15 U.S.C. 272 note). `(8) GOVERNANCE FOR NATIONWIDE HEALTH INFORMATION NETWORK- The National Coordinator shall establish a governance		Background date

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mechanism for the nationwide health information network. `(d) Detail of Federal Employees- `(1) IN GENERAL- Upon the request of the National Coordinator, the head of any Federal agency is authorized to detail, with or without reimbursement from the Office, any of the personnel of such agency to the Office to assist it in carrying out its duties under this section. `(2) EFFECT OF DETAIL- Any detail of personnel under paragraph (1) shall-- `(A) not interrupt or otherwise affect the civil service status or privileges of the Federal employee; and `(B) be in addition to any other staff of the Department employed by the National Coordinator. `(3) ACCEPTANCE OF DETAILEES- Notwithstanding any other provision of law, the Office may accept detailed personnel from other Federal agencies without regard to whether the agency described under paragraph (1) is reimbursed. `(e) Chief Privacy Officer of the Office of the National Coordinator- Not later than 12 months after the date of the enactment of this title, the Secretary shall appoint a Chief Privacy Officer of the Office of the National Coordinator, whose duty it shall be to advise the National Coordinator on privacy, security, and data stewardship of electronic health information and to coordinate with other Federal agencies (and similar privacy officers in such agencies), with State and regional efforts, and with foreign countries with regard to the privacy, security, and data stewardship of electronic individually identifiable health information.		NLT 02/17/2010
Section 3002 – HIT Policy Committee		
`(a) Establishment- There is established a HIT Policy Committee to make policy recommendations to the National Coordinator relating to the implementation of a nationwide health information technology infrastructure, including implementation of the strategic plan described in section 3001(c)(3). `(b) Duties- `(1) RECOMMENDATIONS ON HEALTH INFORMATION	**HIT Policy Committee:** HIMSS supports the provisions to establish a HIT Policy Committee and supports the congressional intent to recognize health IT as a national initiative that will not be subject to the sun-setting provisions in section 14 of the Federal Advisory Committee Act.	

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TECHNOLOGY INFRASTRUCTURE- The HIT Policy Committee shall recommend a policy framework for the development and adoption of a nationwide health information technology infrastructure that permits the electronic exchange and use of health information as is consistent with the strategic plan under section 3001(c)(3) and that includes the recommendations under paragraph (2). The Committee shall update such recommendations and make new recommendations as appropriate. `(2) SPECIFIC AREAS OF STANDARD DEVELOPMENT- `(A) IN GENERAL- The HIT Policy Committee shall recommend the areas in which standards, implementation specifications, and certification criteria are needed for the electronic exchange and use of health information for purposes of adoption under section 3004 and shall recommend an order of priority for the development, harmonization, and recognition of such standards, specifications, and certification criteria among the areas so recommended. Such standards and implementation specifications shall include named standards, architectures, and software schemes for the authentication and security of individually identifiable health information and other information as needed to ensure the reproducible development of common solutions across disparate entities. `(B) AREAS REQUIRED FOR CONSIDERATION- For purposes of subparagraph (A), the HIT Policy Committee shall make recommendations for at least the following areas: `(i) Technologies that protect the privacy of health information and promote security in a qualified electronic health record, including for the segmentation and protection from disclosure of specific and sensitive individually identifiable health information with the goal of minimizing the reluctance of patients to seek care (or disclose information about a condition) because of privacy concerns, in accordance with applicable law, and for the use and disclosure of limited data sets of such information.	HIMSS notes that the development of a HIT Policy Committee would bring decision making and guidance concerning decisions that impact the nationwide exchange and health information infrastructure under the direct supervision of the federal government through federal advisory committees. The American Health Information Community (AHIC) also served as a federal advisory committee before transitioning to the private sector as NeHC. The HIT Policy Committee, which functions as a federal advisory committee (FACA), makes recommendations to the National Coordinator relating the implementation of an NHIN, including implementation of the federal health IT strategic plan. One recommendation the committee must create, and keep updated, is for a policy framework of an NHIN. In general, the committee makes recommendations of areas in which standards, certification requirements, and interoperability specs are needed for e-exchange of health information. The committee also prioritizes these needs. Specifically, the committee shall make recommendations for at least: 1. Technologies that protect the privacy of health information and promote security in a qualified EHR; 2. An NHIN; 3. The utilization of an EHR by each person living in the US by 2014; 4. Accounting for disclosures made by covered entities under HIPAA; 5. The utilization of EHRs to improve the quality of care, reduce medical errors, reduce health disparities, improve care coordination, and advance research & education; 6. Technologies that make individually-identifiable health	

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	`(ii) A nationwide health information technology infrastructure that allows for the electronic use and accurate exchange of health information. `(iii) The utilization of a certified electronic health record for each person in the United States by 2014. `(iv) Technologies that as a part of a qualified electronic health record allow for an accounting of disclosures made by a covered entity (as defined for purposes of regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996) for purposes of treatment, payment, and health care operations (as such terms are defined for purposes of such regulations). `(v) The use of certified electronic health records to improve the quality of health care, such as by promoting the coordination of health care and improving continuity of health care among health care providers, by reducing medical errors, by improving population health, by reducing health disparities, by reducing chronic disease, and by advancing research and education. `(vi) Technologies that allow individually identifiable health information to be rendered unusable, unreadable, or indecipherable to unauthorized individuals when such information is transmitted in the nationwide health information network or physically transported outside of the secured, physical perimeter of a health care provider, health plan, or health care clearinghouse. `(vii) The use of electronic systems to ensure the comprehensive collection of patient demographic data, including, at a minimum, race, ethnicity, primary language, and gender information. `(viii) Technologies that address the needs of children and other vulnerable populations. `(C) OTHER AREAS FOR CONSIDERATION- In making recommendations under subparagraph (A), the	information unreadable, unusable, or indesipherable when transmitted via the NHIN; 7. Using e-systems to collect demographic data; and, 8. Technologies that address the needs of children and other vulnerable populations. Congress gave the committee the latitude to address additional areas. And, Congress states that the committee serves as a forum for broad public input with specific expertise relating to the NHIN. In addition to the National Coordinator – who serves in a leading capacity – the committee consists of many representative stakeholders. Some of the members are appointed by various members of Congress and the President. The Comptroller General appoints 13 individuals. Appointees serve three-year terms. The committee itself can appoint outside advisors. If, within 45 days of enactment of ARRA, one or more officials authorized to make an appointment to the committee fail to do so, the Secretary of HHS will fill the vacancy. The National Coordinator will ensure that relevant recommendations from NCVHS are included in the committee's deliberations.	Background date

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HIT Policy Committee may consider the following additional areas: `(i) The appropriate uses of a nationwide health information infrastructure, including for purposes of-- `(I) the collection of quality data and public reporting; `(II) biosurveillance and public health; `(III) medical and clinical research; and `(IV) drug safety. `(ii) Self-service technologies that facilitate the use and exchange of patient information and reduce wait times. `(iii) Telemedicine technologies, in order to reduce travel requirements for patients in remote areas. `(iv) Technologies that facilitate home health care and the monitoring of patients recuperating at home. `(v) Technologies that help reduce medical errors. `(vi) Technologies that facilitate the continuity of care among health settings. `(vii) Technologies that meet the needs of diverse populations. `(viii) Methods to facilitate secure access by an individual to such individual's protected health information. `(ix) Methods, guidelines, and safeguards to facilitate secure access to patient information by a family member, caregiver, or guardian acting on behalf of a patient due to age-related and other disability, cognitive impairment, or dementia. `(x) Any other technology that the HIT Policy Committee finds to be among the technologies with the greatest potential to improve the quality and efficiency of health care. `(3) FORUM- The HIT Policy Committee shall serve as a forum for broad stakeholder input with specific expertise in policies relating to the matters described in paragraphs (1) and (2). `(4) CONSISTENCY WITH EVALUATION CONDUCTED UNDER		

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MIPPA- `(A) REQUIREMENT FOR CONSISTENCY- The HIT Policy Committee shall ensure that recommendations made under paragraph (2)(B)(vi) are consistent with the evaluation conducted under section 1809(a) of the Social Security Act. `(B) SCOPE- Nothing in subparagraph (A) shall be construed to limit the recommendations under paragraph (2)(B)(vi) to the elements described in section 1809(a)(3) of the Social Security Act. `(C) TIMING- The requirement under subparagraph (A) shall be applicable to the extent that evaluations have been conducted under section 1809(a) of the Social Security Act, regardless of whether the report described in subsection (b) of such section has been submitted. `(c) Membership and Operations- `(1) IN GENERAL- The National Coordinator shall take a leading position in the establishment and operations of the HIT Policy Committee. `(2) MEMBERSHIP- The HIT Policy Committee shall be composed of members to be appointed as follows: `(A) 3 members shall be appointed by the Secretary, 1 of whom shall be appointed to represent the Department of Health and Human Services and 1 of whom shall be a public health official. `(B) 1 member shall be appointed by the majority leader of the Senate. `(C) 1 member shall be appointed by the minority leader of the Senate. `(D) 1 member shall be appointed by the Speaker of the House of Representatives. `(E) 1 member shall be appointed by the minority leader of the House of Representatives. `(F) Such other members as shall be appointed by the President as representatives of other relevant Federal agencies. `(G) 13 members shall be appointed by the Comptroller General of the United States of whom--		

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`(i) 3 members shall advocates for patients or consumers; `(ii) 2 members shall represent health care providers, one of which shall be a physician; `(iii) 1 member shall be from a labor organization representing health care workers; `(iv) 1 member shall have expertise in health information privacy and security; `(v) 1 member shall have expertise in improving the health of vulnerable populations; `(vi) 1 member shall be from the research community; `(vii) 1 member shall represent health plans or other third-party payers; `(viii) 1 member shall represent information technology vendors; `(ix) 1 member shall represent purchasers or employers; and `(x) 1 member shall have expertise in health care quality measurement and reporting. `(3) PARTICIPATION- The members of the HIT Policy Committee appointed under paragraph (2) shall represent a balance among various sectors of the health care system so that no single sector unduly influences the recommendations of the Policy Committee. `(4) TERMS- `(A) IN GENERAL- The terms of the members of the HIT Policy Committee shall be for 3 years, except that the Comptroller General shall designate staggered terms for the members first appointed. `(B) VACANCIES- Any member appointed to fill a vacancy in the membership of the HIT Policy Committee that occurs prior to the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has been appointed. A vacancy in the HIT Policy Committee shall be filled in the manner in which the original		

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appointment was made. `(5) OUTSIDE INVOLVEMENT- The HIT Policy Committee shall ensure an opportunity for the participation in activities of the Committee of outside advisors, including individuals with expertise in the development of policies for the electronic exchange and use of health information, including in the areas of health information privacy and security. `(6) QUORUM- A majority of the member of the HIT Policy Committee shall constitute a quorum for purposes of voting, but a lesser number of members may meet and hold hearings. `(7) FAILURE OF INITIAL APPOINTMENT- If, on the date that is 45 days after the date of enactment of this title, an official authorized under paragraph (2) to appoint one or more members of the HIT Policy Committee has not appointed the full number of members that such paragraph authorizes such official to appoint, the Secretary is authorized to appoint such members. `(8) CONSIDERATION- The National Coordinator shall ensure that the relevant and available recommendations and comments from the National Committee on Vital and Health Statistics are considered in the development of policies. `(d) Application of FACA- The Federal Advisory Committee Act (5 U.S.C. App.), other than section 14 of such Act, shall apply to the HIT Policy Committee. `(e) Publication- The Secretary shall provide for publication in the Federal Register and the posting on the Internet website of the Office of the National Coordinator for Health Information Technology of all policy recommendations made by the HIT Policy Committee under this section.		04/03/2009
Section 3003 – HIT Standards Committee		
`(a) Establishment- There is established a committee to be known as the HIT Standards Committee to recommend to the National Coordinator standards, implementation specifications, and certification criteria for the electronic exchange and use of health information for purposes of adoption under section 3004, consistent with the implementation of the strategic plan described in section	**HIT Standards Committee:** HIMSS supports the provisions to establish a HIT Standards Committee and supports the congressional intent to recognize health IT as a national initiative that will not be subject to the sun-setting provisions in section 14 of the Federal Advisory Committee Act.	

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3001(c)(3) and beginning with the areas listed in section 3002(b)(2)(B) in accordance with policies developed by the HIT Policy Committee. `(b) Duties- `(1) STANDARDS DEVELOPMENT- `(A) IN GENERAL- The HIT Standards Committee shall recommend to the National Coordinator standards, implementation specifications, and certification criteria described in subsection (a) that have been developed, harmonized, or recognized by the HIT Standards Committee. The HIT Standards Committee shall update such recommendations and make new recommendations as appropriate, including in response to a notification sent under section 3004(a)(2)(B). Such recommendations shall be consistent with the latest recommendations made by the HIT Policy Committee. `(B) HARMONIZATION- The HIT Standards Committee recognize harmonized or updated standards from an entity or entities for the purpose of harmonizing or updating standards and implementation specifications in order to achieve uniform and consistent implementation of the standards and implementation specifications. `(C) PILOT TESTING OF STANDARDS AND IMPLEMENTATION SPECIFICATIONS- In the development, harmonization, or recognition of standards and implementation specifications, the HIT Standards Committee shall, as appropriate, provide for the testing of such standards and specifications by the National Institute for Standards and Technology under section 13201(a) of the Health Information Technology for Economic and Clinical Health Act. `(D) CONSISTENCY- The standards, implementation specifications, and certification criteria recommended under this subsection shall be consistent with the standards for information transactions and data elements adopted pursuant to section 1173 of the Social Security Act. `(2) FORUM- The HIT Standards Committee shall serve as a forum for	HIMSS notes that the development of a HIT Standards Committee would bring decision making and guidance concerning decisions that impact the nationwide exchange and health information infrastructure under the direct supervision of the federal government through federal advisory committees. The American Health Information Community (AHIC) also served as a federal advisory committee before transitioning to the private sector as NeHC. **Standards Harmonization:** HIMSS recommends that the Secretary recognize HITSP as the entity for the purpose of harmonizing or updating standards and implementation specifications in order to achieve uniform and consistent implementation of the standards and implementation specifications. HITSP has led the national effort to harmonize interoperability standards to facilitate the secure exchange of health information since it's inception by the American National Standards Institute (ANSI) in 2005. Utilizing the nearly century-old open, inclusive, collaborative volunteer-driven approach developed and tested by ANSI, HITSP's harmonization work incorporates the views of 603 organizational members, of which 22 are consumer organizations, to address such areas as EHRs, biosurveillance, consumer empowerment, medication management, quality, and population health. The HIT Standards Committee, which functions as a federal advisory committee (FACA), recommends standards, implementation specifications, and certification criteria for the electronic exchange and use of health information to the National Coordinator. These recommendations must be in support of section 3004, which calls for a Process for	

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the participation of a broad range of stakeholders to provide input on the development, harmonization, and recognition of standards, implementation specifications, and certification criteria necessary for the development and adoption of a nationwide health information technology infrastructure that allows for the electronic use and exchange of health information. `(3) SCHEDULE- Not later than 90 days after the date of the enactment of this title, the HIT Standards Committee shall develop a schedule for the assessment of policy recommendations developed by the HIT Policy Committee under section 3002. The HIT Standards Committee shall update such schedule annually. The Secretary shall publish such schedule in the Federal Register. `(4) PUBLIC INPUT- The HIT Standards Committee shall conduct open public meetings and develop a process to allow for public comment on the schedule described in paragraph (3) and recommendations described in this subsection. Under such process comments shall be submitted in a timely manner after the date of publication of a recommendation under this subsection. `(5) CONSIDERATION- The National Coordinator shall ensure that the relevant and available recommendations and comments from the National Committee on Vital and Health Statistics are considered in the development of standards. `(c) Membership and Operations- `(1) IN GENERAL- The National Coordinator shall take a leading position in the establishment and operations of the HIT Standards Committee. `(2) MEMBERSHIP- The membership of the HIT Standards Committee shall at least reflect providers, ancillary healthcare workers, consumers, purchasers, health plans, technology vendors, researchers, relevant Federal agencies, and individuals with technical expertise on health care quality, privacy and security, and on the electronic exchange and use of health information. `(3) PARTICIPATION- The members of the HIT Standards Committee appointed under this subsection shall represent a balance among various sectors of the health care system so that no single sector unduly influences the recommendations of such Committee.	Adoption of Endorsed Recommendations. The recommendations must be consistent with the implementation roadmap laid out in the federal health IT strategic plan. In general, the Committee recommends – and keeps updated such recommendations updated for – standards, implementation specifications, and certification criteria that have been developed, harmonized, or recognized by the Committee. The committee's recommendations are to be consistent with those of the HIT Policy Committee. The committee recognizes harmonized or updated standards from an entity that harmonizes or updates standards and implementation guidelines. Such an entity must exist to achieve uniform and consistent implementations of the standards and implementation specs. Not later than 90 days upon enactment, the committee must develop a schedule for the assessment of policy recommendations developed by the HIT Policy Committee (see section 3002). This schedule must be published annually in the Federal Register. Also, the committee must develop a process to allow for public comment, and host open public meetings. The National Coordinator must ensure that recommendations from the NCVHS are incorporated into the work of the committee. The membership of the committee must include a wide variety of stakeholders, including but not limited to, providers, ancillary healthcare workers, consumers, purchasers, researchers, and vendors. And, the group must be balanced so that one voice does not dominate the group's efforts.	NLT 05/18/2009

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`(4) OUTSIDE INVOLVEMENT- The HIT Policy Committee shall ensure an opportunity for the participation in activities of the Committee of outside advisors, including individuals with expertise in the development of standards for the electronic exchange and use of health information, including in the areas of health information privacy and security. `(5) BALANCE AMONG SECTORS- In developing the procedures for conducting the activities of the HIT Standards Committee, the HIT Standards Committee shall act to ensure a balance among various sectors of the health care system so that no single sector unduly influences the actions of the HIT Standards Committee. `(6) ASSISTANCE- For the purposes of carrying out this section, the Secretary may provide or ensure that financial assistance is provided by the HIT Standards Committee to defray in whole or in part any membership fees or dues charged by such Committee to those consumer advocacy groups and not for profit entities that work in the public interest as a part of their mission. `(d) Application of FACA- The Federal Advisory Committee Act (5 U.S.C. App.), other than section 14, shall apply to the HIT Standards Committee. `(e) Publication- The Secretary shall provide for publication in the Federal Register and the posting on the Internet website of the Office of the National Coordinator for Health Information Technology of all recommendations made by the HIT Standards Committee under this section.		
Section 3004 – Process for Adoption of Endorsed Recommendations; Adoption of Initial Set of Standards, Implementation Specifications, and Certification Criteria		
`(a) Process for Adoption of Endorsed Recommendations- `(1) REVIEW OF ENDORSED STANDARDS, IMPLEMENTATION SPECIFICATIONS, AND CERTIFICATION CRITERIA- Not later than 90 days after the date of receipt of standards, implementation specifications, or certification criteria endorsed under section 3001(c), the Secretary, in consultation with representatives of other relevant Federal	**Review of Existing Standards, Implementation Specification, or Certification Criteria:** HIMSS supports these provisions and strongly encourages HHS to adopt the work of CCHIT and HITSP to-date and continue the collaboration with CCHIT and HITSP for reasons as detailed above. As detailed above, both organizations have made great	NLT 05/18/2009

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agencies, shall jointly review such standards, implementation specifications, or certification criteria and shall determine whether or not to propose adoption of such standards, implementation specifications, or certification criteria. `(2) DETERMINATION TO ADOPT STANDARDS, IMPLEMENTATION SPECIFICATIONS, AND CERTIFICATION CRITERIA- If the Secretary determines-- `(A) to propose adoption of any grouping of such standards, implementation specifications, or certification criteria, the Secretary shall, by regulation under section 553 of title 5, United States Code, determine whether or not to adopt such grouping of standards, implementation specifications, or certification criteria; or `(B) not to propose adoption of any grouping of standards, implementation specifications, or certification criteria, the Secretary shall notify the National Coordinator and the HIT Standards Committee in writing of such determination and the reasons for not proposing the adoption of such recommendation. `(3) PUBLICATION- The Secretary shall provide for publication in the Federal Register of all determinations made by the Secretary under paragraph (1). `(b) Adoption of Standards, Implementation Specifications, and Certification Criteria- `(1) IN GENERAL- Not later than December 31, 2009, the Secretary shall, through the rulemaking process consistent with subsection (a)(2)(A), adopt an initial set of standards, implementation specifications, and certification criteria for the areas required for consideration under section 3002(b)(2)(B). The rulemaking for the initial set of standards, implementation specifications, and certification criteria may be issued on an interim, final basis. `(2) APPLICATION OF CURRENT STANDARDS, IMPLEMENTATION SPECIFICATIONS, AND CERTIFICATION CRITERIA- The standards, implementation specifications, and certification criteria adopted before the date of the enactment of this title	strides for the community. **Adoption of Initial Set of Standards, Implementation Specifications, and Certification Criteria:** HIMSS supports the provision for the Secretary, through a rule making process, to adopt an initial set of standards, implementation specifications, and certification criteria no later than December 31, 2009. HIMSS asserts that industry needs 12 months to provide appropriate technical support to federal agencies to ensure the federal products are consistent with standards committee recommendations. The provisions aim to ensure that standards, implementation specifications, and certification criteria are addressed in a timely manner not to impede market activity. In an effort to not disregard the work of the public and private sector to date in the areas of the harmonization of standards and the certification of health IT product, the Secretary shall recognize the current work and progress made by HITSP and CCHIT in these areas. Providers should not wait to pursue the adoption of health IT until an initial set of standards, implementation specifications, and certification criteria are adopted by the federal as required under this legislation. Providers should begin to explore those products that are already CCHIT and determine what products are best for their facility. If providers delay the acquisition process, providers risk not being fully prepared to demonstrate a “meaningful use of certified EHRs” by fiscal year 2011 and therefore not being able to qualify for incentives through Medicare and Medicaid.	NLT 12/31/2009

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through the process existing through the Office of the National Coordinator for Health Information Technology may be applied towards meeting the requirement of paragraph (1). `(3) SUBSEQUENT STANDARDS ACTIVITY- The Secretary shall adopt additional standards, implementation specifications, and certification criteria as necessary and consistent with the schedule published under section 3003(b)(2).		
Section 3005 – Application and Use of Adopted Standards and Implementation Specifications by Federal Agencies		
For requirements relating to the application and use by Federal agencies of the standards and implementation specifications adopted under section 3004, see section 13111 of the Health Information Technology for Economic and Clinical Health Act	**Application and Use of Adopted Standards and Implementation Specifications by Federal Agencies:** HIMSS supports this provision to require the Federal Employees Health Benefits Program (FEHBP), Medicare, IHS, TRICARE and Department of Veteran Affairs to implement, acquire, or upgrade health IT systems, where available, that meets standards and implementation specifications adopted under Section 3004. HIMSS urges Congress and the President to include Medicaid as a required entity. Such a measure ensures that tax payers' dollars are spent appropriately and federal government and the private sector are taking another step towards ensuring the widespread, appropriate, and secure interoperable exchange of health information. HIMSS addressed the use of uniform standards and products in a recommendation included in *"Enabling Healthcare Reform Using Information Technology"*. As stated, HIMSS believes that the US Congress should mandate that any funding appropriated for the purchase or upgrade of new health IT products among providers and payors of federally funded health programs only be allocated for the use of health IT products that apply HITSP interoperability specifications	

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	and are CCHIT-certified. HIMSS believes that this requirement should only be enforced when appropriate standards and certified products are available on the market. In addition, not later than December 31, 2014, all federally funded health programs and all organizations that directly conduct business with federally funded health program must adhere to these same requirements.	
Section 3006 – Voluntary Application and Use of Adopted Standards and Implementation Specifications by Private Entities		
`(a) In General- Except as provided under section 13112 of the HITECH Act, nothing in such Act or in the amendments made by such Act shall be construed-- `(1) to require a private entity to adopt or comply with a standard or implementation specification adopted under section 3004; or `(2) to provide a Federal agency authority, other than the authority such agency may have under other provisions of law, to require a private entity to comply with such a standard or implementation specification. `(b) Rule of Construction- Nothing in this subtitle shall be construed to require that a private entity that enters into a contract with the Federal Government apply or use the standards and implementation specifications adopted under section 3004 with respect to activities not related to the contract.	**Voluntary Application and Use of Adoption Standards Implementation Specifications by Private Entities:** HIMSS supports the provision that the standards and implementation specifications adopted under this Act should not apply to other departments and agencies that are not associated with FEHBP, Medicare, IHS, TRICARE and the VA. HIMSS recommends that Congress include the Medicaid program for inclusion as well in the requirement.	
Section 3007 – Federal Health Information Technology		
`(a) In General- The National Coordinator shall support the development and routine updating of qualified electronic health record technology (as defined in section 3000) consistent with subsections (b) and (c) and make available such qualified electronic health record technology unless the Secretary determines through an assessment that the needs and demands of providers are being substantially and adequately met through the marketplace. `(b) Certification- In making such electronic health record technology publicly available, the National Coordinator shall ensure that the qualified electronic health record technology described in subsection (a) is certified under the program developed under section 3001(c)(3) to be in compliance with applicable standards adopted under section 3003(a). `(c) Authorization To Charge a Nominal Fee- The National Coordinator may	**Federal Health Information Technology:** HIMSS strongly believes that the marketplace does not need the federal government to support the development, routine updating and provision of qualified EHR technology. Rather, HIMSS strongly believes that the needs and demands of providers are being substantially and adequately met through the marketplace. The health IT industry has increasing numbers of CCHIT-certified EHR systems representing a wide array of features and functionality for both the acute and ambulatory care settings.	

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impose a nominal fee for the adoption by a health care provider of the health information technology system developed or approved under subsection (a) and (b). Such fee shall take into account the financial circumstances of smaller providers, low income providers, and providers located in rural or other medically underserved areas. `(d) Rule of Construction- Nothing in this section shall be construed to require that a private or government entity adopt or use the technology provided under this section.		
Section 3008 - Transitions		
`(a) ONCHIT- To the extent consistent with section 3001, all functions, personnel, assets, liabilities, and administrative actions applicable to the National Coordinator for Health Information Technology appointed under Executive Order No. 13335 or the Office of such National Coordinator on the date before the date of the enactment of this title shall be transferred to the National Coordinator appointed under section 3001(a) and the Office of such National Coordinator as of the date of the enactment of this title. `(b) National EHealth Collaborative- Nothing in sections 3002 or 3003 or this subsection shall be construed as prohibiting the AHIC Successor, Inc. doing business as the National eHealth Collaborative from modifying its charter, duties, membership, and any other structure or function required to be consistent with section 3002 and 3003 so as to allow the Secretary to recognize such AHIC Successor, Inc. as the HIT Policy Committee or the HIT Standards Committee. `(c) Consistency of Recommendations- In carrying out section 3003(b)(1)(A), until recommendations are made by the HIT Policy Committee, recommendations of the HIT Standards Committee shall be consistent with the most recent recommendations made by such AHIC Successor, Inc.	**Transitions of the National Coordinator and National eHealth Collaborative:** HIMSS supports these provisions to help ensure the National Coordinator and the HIT Policy Committee and the HIT Standards Committee, as established under this legislation, would have the needed resources to build upon the policy developed by the National Coordinator and AHIC to date. Under this provision, the Secretary would have the opportunity to recognize the National eHealth Collaborative as the HIT Standards Committee or the HIT Policy Committee– if NeHC wishes to modify its charter. By modifying its charter to become a federal advisory committee, and by serving as the HIT Standards Committee, NeHC would receive support and endorsement by the federal government. Before the emergence of NeHC in the private sector, AHIC served as a federal advisory committee.	
Section 3009 - Relation to HIPAA Privacy and Security Law		
`(a) Relation to HIPAA Privacy and Security Law- `(1) IN GENERAL- With respect to the relation of this title to HIPAA privacy and security law: `(A) This title may not be construed as having any effect on the	**Relation to HIPAA Privacy and Security Law:** HIMSS supports this provision.	

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authorities of the Secretary under HIPAA privacy and security law. `(B) The purposes of this title include ensuring that the health information technology standards and implementation specifications adopted under section 3004 take into account the requirements of HIPAA privacy and security law. `(2) DEFINITION- For purposes of this section, the term `HIPAA privacy and Security law' means-- `(A) the provisions of part C of title XI of the Social Security Act, section 264 of the Health Insurance Portability and Accountability Act of 1996, and subtitle D of title IV of the Health Information Technology for Economic and Clinical Health Act; and `(B) regulations under such provisions. `(b) Flexibility- In administering the provisions of this title, the Secretary shall have flexibility in applying the definition of health care provider under section 3000(3), including the authority to omit certain entities listed in such definition when applying such definition under this title, where appropriate.'.		
PART II – Application and Use of Adopted Health Information Technology Standards; Reports **Section 13111 – Coordination of Federal Activities with Adopted Standards and Implementation Specifications**		
(a) Spending on Health Information Technology Systems- As each agency (as defined by the Director of the Office of Management and Budget, in consultation with the Secretary of Health and Human Services) implements, acquires, or upgrades health information technology systems used for the direct exchange of individually identifiable health information between agencies and with non-Federal entities, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under section 3004 of the Public Health Service Act, as added by section 13101. (b) Federal Information Collection Activities- With respect to a standard or implementation specification adopted under section 3004 of the Public Health	**Application and Use of Adopted Health Information Technology Standards:** HIMSS supports this provision to require the FEHBP, Medicare, IHS, TRICARE and the VA to implement, acquire, or upgrade health IT systems, where available, that meets standards and implementation specifications adopted under Section 3004. HIMSS urges Congress and the President to include Medicaid as a required entity. Such a measure ensures that tax payers' dollars are spent appropriately, and that the federal government and the private sector are taking another step towards ensuring the widespread, interoperable exchange of health information.	

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Service Act, as added by section 13101, the President shall take measures to ensure that Federal activities involving the broad collection and submission of health information are consistent with such standard or implementation specification, respectively, within three years after the date of such adoption. (c) Application of Definitions- The definitions contained in section 3000 of the Public Health Service Act, as added by section 13101, shall apply for purposes of this part.	HIMSS recently addressed the use of uniform standards and products in a recommendation included in *"Enabling Healthcare Reform Using Information Technology"*. As stated in the report, HIMSS believes that the US Congress should mandate that any funding appropriated for the purchase or upgrade of new health IT products among providers and payors of federally funded health programs only be allocated for the use of health IT products that apply HITSP interoperability specifications and are CCHIT-certified. HIMSS believes that this requirement should only be enforced when appropriate standards and certified products are available on the market. In addition, not later than December 31, 2014, all federally funded health programs and all organizations that directly conduct business with federally funded health program must adhere to these same requirements. .	
Section 13112 – Application to Private Entities		
Each agency, as defined in the August 22, 2006 Executive Order, shall require in contracts or agreements with healthcare providers, health plans, or health insurance issuers that as each provider, plan, or issuer implements, acquires, or upgrades health IT systems, it shall utilize, where available, health IT systems and products that meet standards and implementation specifications, adopted under Section 3004.	**Application and Use of Adopted Health Information Technology Standards in Contracts and Agreements:** HIMSS supports this provision to require all contracts or agreements with healthcare providers, health plans, or health insurance issuers by the FEHBP, Medicare, IHS, TRICARE and the VA to implement, acquire, or upgrade health IT systems, where available, that meets standards and implementation specifications adopted under Section 3004. In addition, HIMSS urges Congress and the President to implement the same requirements for contracts or agreements between Medicaid and healthcare providers, health plans or health insurance insurers. Such a measure ensures that tax payers' dollars are spent appropriately, and that the federal government and the private sector are taking another step towards ensuring the widespread, interoperable exchange of	

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	health information. HIMSS recently addressed the use of uniform standards and products in a recommendation included in *"Enabling Healthcare Reform Using Information Technology"*. As stated in the report, HIMSS believes that the US Congress should mandate that any funding appropriated for the purchase or upgrade of new health IT products among providers and payors of federally funded health programs only be allocated for the use of health IT products that apply HITSP interoperability specifications and are CCHIT-certified. HIMSS believes that this requirement should only be enforced when appropriate standards and certified products are available on the market. In addition, not later than December 31, 2014, all federally funded health programs and all organizations that directly conduct business with federally funded health program must adhere to these same requirements.	
Section 13113 – Study and Reports		
No later than two years after the date of enactment of the Act, the Secretary of HHS shall submit to the House Appropriations Committees of jurisdiction a report on the actions taken by the Federal Government and private entities to facilitate the adoption of a nationwide system for the electronic use and exchange of health information; describe the barriers to adoption of such a nationwide system; and contain recommendations to achieve implementation of such a nationwide system. The Secretary shall also carry out a report that examines methods to create efficient reimbursement incentives for improving healthcare quality in federally qualified health centers, rural health clinics, and free clinics. No later than 2 years after the date of enactment of the Act, the Secretary shall submit to the appropriate committees of jurisdiction of the House of Representatives and the Senate a report on the study. The Secretary should carry out a report to study the matters relation to the potential use of new aging services technologies. No later than 24 months	**Study and Reports:** HIMSS supports these provisions to provide Congressional oversight on activities carried out under this legislation. HIMSS strongly believes that accountability in the spending of these funds is of key importance.	NLT 02/17/2011 NLT 02/17/2011

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after the date of the enactment of this Act, the Secretary shall submit to the appropriate committees of jurisdiction of the House of Representatives and of the Senate a report on the study.		NLT 02/17/2011
Subtitle B – Testing of Health Information Technology **Section 13201 – National Institute for Standards and Technology Testing**		
(a) Pilot Testing of Standards and Implementation Specifications- In coordination with the HIT Standards Committee established under section 3003 of the Public Health Service Act, as added by section 13101, with respect to the development of standards and implementation specifications under such section, the Director of the National Institute for Standards and Technology shall test such standards and implementation specifications, as appropriate, in order to assure the efficient implementation and use of such standards and implementation specifications. (b) Voluntary Testing Program- In coordination with the HIT Standards Committee established under section 3003 of the Public Health Service Act, as added by section 13101, with respect to the development of standards and implementation specifications under such section, the Director of the National Institute of Standards and Technology shall support the establishment of a conformance testing infrastructure, including the development of technical test beds. The development of this conformance testing infrastructure may include a program to accredit independent, non-Federal laboratories to perform testing.	**Role of the National Institute of Standards and Technology and Testing:** HIMSS supports the provision for NIST to test standards and implementation specifications and strongly encourages NIST to continue its strong relationship with HITSP, IHE, and CCHIT in order to advance current efforts to collaboratively develop public domain testing tools and convene events and activities to test standards and implementation specifications.	
Section 13202 – Research and Development Programs		
(a) Health Care Information Enterprise Integration Research Centers- (1) IN GENERAL- The Director of the National Institute of Standards and Technology, in consultation with the Director of the National Science Foundation and other appropriate Federal agencies, shall establish a program of assistance to institutions of higher education (or consortia thereof which may include nonprofit entities and Federal Government laboratories) to establish multidisciplinary Centers for Health Care Information Enterprise Integration. (2) REVIEW; COMPETITION- Grants shall be awarded under this	**Centers for Health Care Information Enterprise Integration:** HIMSS supports the provision to establish Centers for Health Care Information Enterprise Integration and notes that this provision, through a grant program to institutions of higher education, will aid in developing cutting-edge IT innovation that can be applied to improve the delivery of healthcare. Such efforts maintain the strength of the United States as a world-leader in technology research & development.	

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subsection on a merit-reviewed, competitive basis. (3) PURPOSE- The purposes of the Centers described in paragraph (1) shall be-- (A) to generate innovative approaches to health care information enterprise integration by conducting cutting-edge, multidisciplinary research on the systems challenges to health care delivery; and (B) the development and use of health information technologies and other complementary fields. (4) RESEARCH AREAS- Research areas may include-- (A) interfaces between human information and communications technology systems; (B) voice-recognition systems; (C) software that improves interoperability and connectivity among health information systems; (D) software dependability in systems critical to health care delivery; (E) measurement of the impact of information technologies on the quality and productivity of health care; (F) health information enterprise management; (G) health information technology security and integrity; and (H) relevant health information technology to reduce medical errors. (5) APPLICATIONS- An institution of higher education (or a consortium thereof) seeking funding under this subsection shall submit an application to the Director of the National Institute of Standards and Technology at such time, in such manner, and containing such information as the Director may require. The application shall include, at a minimum, a description of-- (A) the research projects that will be undertaken by the Center established pursuant to assistance under paragraph (1) and the respective contributions of the participating entities; (B) how the Center will promote active collaboration among scientists and engineers from different disciplines, such as		

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information technology, biologic sciences, management, social sciences, and other appropriate disciplines; (C) technology transfer activities to demonstrate and diffuse the research results, technologies, and knowledge; and (D) how the Center will contribute to the education and training of researchers and other professionals in fields relevant to health information enterprise integration. (b) National Information Technology Research and Development Program- The National High-Performance Computing Program established by section 101 of the High-Performance Computing Act of 1991 (15 U.S.C. 5511) shall include Federal research and development programs related to health information technology.		
Title XXX of the Public Health Service Act, as added by Section 13101, is amended by adding at the end the following new Subtitle: Incentives for the Use of Health Information Technology	No comment necessary.	

Section 3011 – Immediate Funding to Strengthen the Health Information Technology Infrastructure		
`(a) In General- The Secretary shall, using amounts appropriated under section 3018, invest in the infrastructure necessary to allow for and promote the electronic exchange and use of health information for each individual in the United States consistent with the goals outlined in the strategic plan developed by the National Coordinator (and as available) under section 3001. The Secretary shall invest funds through the different agencies with expertise in such goals, such as the Office of the National Coordinator for Health Information Technology, the Health Resources and Services Administration, the Agency for Healthcare Research and Quality, the Centers of Medicare & Medicaid Services, the Centers for Disease Control and Prevention, and the Indian Health Service to support the following: `(1) Health information technology architecture that will support the nationwide electronic exchange and use of health information in a secure, private, and accurate manner, including connecting health information exchanges, and which may include updating and implementing the infrastructure necessary within different agencies of the Department of Health and Human Services to support the electronic use and exchange of health information. `(2) Development and adoption of appropriate certified electronic health records for categories of health care providers not eligible for support under title XVIII or XIX of the Social Security Act for the adoption of such records. `(3) Training on and dissemination of information on best practices to integrate health information technology, including electronic health records, into a provider's delivery of care, consistent with best practices learned from the	**Allocation of Funding:** HIMSS supports these provisions to invest in the infrastructure necessary to allow for and promote nationwide electronic exchange and use of health information that are in alignment with the goals of the ONC, the Health Resources and Services Administration (HRSA), AHRQ, CMS, the Centers for Disease Control and Prevention (CDC), and the IHS. Using funds authorized and appropriated under this subtitle, the Secretary is to invest in the infrastructure necessary to allow for, and promote the e-exchange and use of, health information for everyone living in the United States [subsection (a)]. The investment is to be divided among agencies such as CMS, HRSA, AHRQ, IHS, CDC, and ONC. And, the investment must be in accordance with the National Coordinator's strategic plan – as amended by Congress in Section 3001. Under Section 3001, Congress' direction to the National Coordinator included adding to the strategic plan such items as, but not limited to, the utilization of an EHR for everyone living in the US by 2014; privacy & security protections for the e-exchange of health information; fostering public understanding of health IT; enterprise integration; and, specific plans to ensure that the needs of special populations – such as children – are addressed under subsection (c)(3)(A) of section3001. The investment must support seven areas: 1. Health IT architecture [subsection (a)(1)] that will, in turn, support the nationwide use and exchange of health information securely, privately, and accurately. This includes connecting HIEs, and may also include updating the infrastructure within various HHS agencies, so that they can support the e-exchange of health information. 2. Development and adoption of certified EHRs for categories of healthcare providers that are not eligible for support for the adoption of EHRs under title XVIII (health insurance for the aged and disabled) or title XIX (grants to States for Medical Assistance Programs) of the Social Security Act. Training and information dissemination on best practices to integrate health IT – including EHRs – into the delivery of care. These best practices must	Upon Enactment

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Health Information Technology Research Center developed under section 3012(b), including community health centers receiving assistance under section 330, covered entities under section 340B, and providers participating in one or more of the programs under titles XVIII, XIX, and XXI of the Social Security Act (relating to Medicare, Medicaid, and the State Children's Health Insurance Program). `(4) Infrastructure and tools for the promotion of telemedicine, including coordination among Federal agencies in the promotion of telemedicine. `(5) Promotion of the interoperability of clinical data repositories or registries. `(6) Promotion of technologies and best practices that enhance the protection of health information by all holders of individually identifiable health information. `(7) Improvement and expansion of the use of health information technology by public health departments. `(b) Coordination- The Secretary shall ensure funds under this section are used in a coordinated manner with other health information promotion activities. `(c) Additional Use of Funds- In addition to using funds as provided in subsection (a), the Secretary may use amounts appropriated under section 3018 to carry out health information technology activities that are provided for under laws in effect on the date of the enactment of this title. `(d) Standards for Acquisition of Health Information Technology- To the greatest extent practicable, the Secretary shall ensure that where funds are expended	be consistent with the findings of the Health IT Technology Research Center (see section 3012b), and must be distributed widely to providers of many kinds of Telemedicine infrastructure and tools – including coordination among Federal agencies in the promotion of telemedicine. 3. Promoting interoperability of clinical data repositories or registries. 4. Promotion of best practices to enhance the protection of individually-identifiable health information. 5. Expanding the use of health IT by public health departments [subsection (a)(7). In addition, the Secretary has the latitude to use the funds to carry out additional activities that meet the intent of this section, but not specifically identified. And, the Secretary is to ensure the funds are used in a coordinated fashion with other health IT promotion activities. Finally, the Secretary is directed by Congress to use the funds – to the greatest extent possible – to acquire only that technology that meets the criteria outlined in Section 3004. When that requirement is not practical, the Secretary will ensure the acquired health IT meets other applicable standards adopted by the Secretary [subsection (d)]. As noted in Section 3004, the Secretary must adopt an initial set of standards no later than December 31, 2009 [subsection (b)(1) of Section 3004].	

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under this section for the acquisition of health information technology, such funds shall be used to acquire health information technology that meets applicable standards adopted under section 3004. Where it is not practicable to expend funds on health information technology that meets such applicable standards, the Secretary shall ensure that such health information technology meets applicable standards otherwise adopted by the Secretary.		
Section 3012 – Health Information Technology Implementation Assistance		
`(a) Health Information Technology Extension Program- To assist health care providers to adopt, implement, and effectively use certified EHR technology that allows for the electronic exchange and use of health information, the Secretary, acting through the Office of the National Coordinator, shall establish a health information technology extension program to provide health information technology assistance services to be carried out through the Department of Health and Human Services. The National Coordinator shall consult with other Federal agencies with demonstrated experience and expertise in information technology services, such as the National Institute of Standards and Technology, in developing and implementing this program. `(b) Health Information Technology Research Center- `(1) IN GENERAL- The Secretary shall create a Health Information Technology Research Center (in this section referred to as the `Center') to provide technical assistance and develop or recognize best practices to support	**Health Information Technology Research Center:** The provisions direct the Office of the National Coordinator to establish assistance services and a National Health IT Research Center to aid in the dissemination of information concerning of best practices in adopting and implementing health IT, as well as provide technical assistance for entities. In addition, the provisions establish regional centers that can be affiliated with any US-based nonprofit institution. These Regional Centers – tasked with disseminating education and assistance from the National Center – will receive 50% of their funding from the federal government. The rest must be generated through non-federal means. This requirement can be waived by Congress if the Secretary demonstrates that national economic conditions make the requirement unworkable. HIMSS agrees that the Office of the National Coordinator is the appropriate place to coordinate a federal health IT portal, that will include resources and activities being supported by AHRQ, HRSA, and other federal agencies engaged in provider education on HIT activities. HIMSS also notes that the HIMSS Davies Award of Excellence has been recognizing healthcare organizations, ambulatory practices, public health entities,	

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and accelerate efforts to adopt, implement, and effectively utilize health information technology that allows for the electronic exchange and use of information in compliance with standards, implementation specifications, and certification criteria adopted under section 3004. `(2) INPUT- The Center shall incorporate input from-- `(A) other Federal agencies with demonstrated experience and expertise in information technology services such as the National Institute of Standards and Technology; `(B) users of health information technology, such as providers and their support and clerical staff and others involved in the care and care coordination of patients, from the health care and health information technology industry; and `(C) others as appropriate. `(3) PURPOSES- The purposes of the Center are to-- `(A) provide a forum for the exchange of knowledge and experience; `(B) accelerate the transfer of lessons learned from existing public and private sector initiatives, including those currently receiving Federal financial support; `(C) assemble, analyze, and widely disseminate evidence and experience related to the adoption, implementation,	and community health organizations for excellence in the implementation and use of electronic health records for more than a decade. This large database has first-person case studies of what worked and what didn't, the successes, lessons learned, and return on investment experienced from use of EHRs.	

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and effective use of health information technology that allows for the electronic exchange and use of information including through the regional centers described in subsection (c); `(D) provide technical assistance for the establishment and evaluation of regional and local health information networks to facilitate the electronic exchange of information across health care settings and improve the quality of health care; `(E) provide technical assistance for the development and dissemination of solutions to barriers to the exchange of electronic health information; and `(F) learn about effective strategies to adopt and utilize health information technology in medically underserved communities. `(c) Health Information Technology Regional Extension Centers- `(1) IN GENERAL- The Secretary shall provide assistance for the creation and support of regional centers (in this subsection referred to as `regional centers') to provide technical assistance and disseminate best practices and other information learned from the Center to support and accelerate efforts to adopt, implement, and effectively utilize health information technology that allows for the electronic exchange and use of information in compliance with standards, implementation		

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specifications, and certification criteria adopted under section 3004. Activities conducted under this subsection shall be consistent with the strategic plan developed by the National Coordinator, (and, as available) under section 3001. `(2) AFFILIATION- Regional centers shall be affiliated with any United States-based nonprofit institution or organization, or group thereof, that applies and is awarded financial assistance under this section. Individual awards shall be decided on the basis of merit. `(3) OBJECTIVE- The objective of the regional centers is to enhance and promote the adoption of health information technology through-- `(A) assistance with the implementation, effective use, upgrading, and ongoing maintenance of health information technology, including electronic health records, to healthcare providers nationwide; `(B) broad participation of individuals from industry, universities, and State governments; `(C) active dissemination of best practices and research on the implementation, effective use, upgrading, and ongoing maintenance of health information technology, including electronic health records, to health care providers in order to improve the quality of healthcare and protect the privacy and security of health information;		

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`(D) participation, to the extent practicable, in health information exchanges; `(E) utilization, when appropriate, of the expertise and capability that exists in Federal agencies other than the Department; and `(F) integration of health information technology, including electronic health records, into the initial and ongoing training of health professionals and others in the healthcare industry that would be instrumental to improving the quality of healthcare through the smooth and accurate electronic use and exchange of health information. `(4) REGIONAL ASSISTANCE- Each regional center shall aim to provide assistance and education to all providers in a region, but shall prioritize any direct assistance first to the following: `(A) Public or not-for-profit hospitals or critical access hospitals. `(B) Federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act). `(C) Entities that are located in rural and other areas that serve uninsured, underinsured, and medically underserved individuals (regardless of whether such area is urban or rural). `(D) Individual or small group practices (or a consortium thereof) that are primarily focused on primary care.		

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`(5) FINANCIAL SUPPORT- The Secretary may provide financial support to any regional center created under this subsection for a period not to exceed four years. The Secretary may not provide more than 50 percent of the capital and annual operating and maintenance funds required to create and maintain such a center, except in an instance of national economic conditions which would render this cost-share requirement detrimental to the program and upon notification to Congress as to the justification to waive the cost-share requirement. `(6) NOTICE OF PROGRAM DESCRIPTION AND AVAILABILITY OF FUNDS- The Secretary shall publish in the Federal Register, not later than 90 days after the date of the enactment of this title, a draft description of the program for establishing regional centers under this subsection. Such description shall include the following: `(A) A detailed explanation of the program and the programs goals. `(B) Procedures to be followed by the applicants. `(C) Criteria for determining qualified applicants. `(D) Maximum support levels expected to be available to centers under the program. `(7) APPLICATION REVIEW- The Secretary shall subject each application under this subsection to merit review. In making a decision whether to approve such application		NLT 04/03/2009

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and provide financial support, the Secretary shall consider at a minimum the merits of the application, including those portions of the application regarding-- `(A) the ability of the applicant to provide assistance under this subsection and utilization of health information technology appropriate to the needs of particular categories of health care providers; `(B) the types of service to be provided to health care providers; `(C) geographical diversity and extent of service area; and `(D) the percentage of funding and amount of in-kind commitment from other sources. `(8) BIENNIAL EVALUATION- Each regional center which receives financial assistance under this subsection shall be evaluated biennially by an evaluation panel appointed by the Secretary. Each evaluation panel shall be composed of private experts, none of whom shall be connected with the center involved, and of Federal officials. Each evaluation panel shall measure the involved center's performance against the objective specified in paragraph (3). The Secretary shall not continue to provide funding to a regional center unless its evaluation is overall positive. `(9) CONTINUING SUPPORT- After the second year of assistance under this subsection, a regional center may receive additional support under this subsection if it has received positive evaluations and a finding by the Secretary that continuation of Federal funding to the center was in the best interest of provision of health		Background Date

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information technology extension services.		
Section 3013 – State Grants to Promote Health Information Technology		
`(a) In General- The Secretary, acting through the National Coordinator, shall establish a program in accordance with this section to facilitate and expand the electronic movement and use of health information among organizations according to nationally recognized standards. `(b) Planning Grants- The Secretary may award a grant to a State or qualified State-designated entity (as described in subsection (f)) that submits an application to the Secretary at such time, in such manner, and containing such information as the Secretary may specify, for the purpose of planning activities described in subsection (d). `(c) Implementation Grants- The Secretary may award a grant to a State or qualified State designated entity that-- `(1) has submitted, and the Secretary has approved, a plan described in subsection (e) (regardless of whether such plan was prepared using amounts awarded under subsection (b); and `(2) submits an application at such time, in such manner, and containing such information as the Secretary may specify. `(d) Use of Funds- Amounts received under a grant under subsection (c) shall be used to conduct activities to facilitate and expand the electronic movement and use of health information among organizations according to nationally recognized standards through	**Grants to the Electronic Movement and Use of Health Information:** HIMSS supports the provision to establish grants to a State or qualified State designated entity to facilitate /expand use and participation in nationwide exchange of health information. This provision is in alignment with HIMSS' Legislative Principles. Using funds authorized and appropriated under this subtitle, the Secretary – acting through the National Coordinator – may award grants to States or State-designated entities to achieve one or more of the following [sub-section d]: 1. broad and varied participation in nationwide exchange and use of health information 2. identification of State or local resources that work towards a nationwide effort to promote health IT 3. complementing Federal grants, programs, and efforts promoting health IT 4. technical assistance designed to overcome the barriers to the e-exchange of health information 5. effective strategies to enable medically underserved communities to adopt and use health IT 6. assisting patients to use health IT 7. encouraging clinicians to work with health IT regional extension centers (see section 3012) 8. supporting public health agencies authorized use and access to e-health information 9. promoting the use of EHRs for quality improvement via quality reporting 10. other uses as determined by the Secretary The grants can take one of two forms: one to plan for, and another to implement, activities outlined above. To be eligible for a grant, the State or State-designed entity must submit a plan to	

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activities that include-- `(1) enhancing broad and varied participation in the authorized and secure nationwide electronic use and exchange of health information; `(2) identifying State or local resources available towards a nationwide effort to promote health information technology; `(3) complementing other Federal grants, programs, and efforts towards the promotion of health information technology; `(4) providing technical assistance for the development and dissemination of solutions to barriers to the exchange of electronic health information; `(5) promoting effective strategies to adopt and utilize health information technology in medically underserved communities; `(6) assisting patients in utilizing health information technology; `(7) encouraging clinicians to work with Health Information Technology Regional Extension Centers as described in section 3012, to the extent they are available and valuable; `(8) supporting public health agencies' authorized use of and access to electronic health information; `(9) promoting the use of electronic health records for quality improvement including through quality measures reporting; and `(10) such other activities as the Secretary may specify. `(e) Plan- `(1) IN GENERAL- A plan described in this subsection is a plan that describes the activities	the Secretary of HHS. These plans must include all of the following elements [subsection (e)(2)]: 1. In the public interest 2. Consistency with the National Coordinator's strategic plan 3. Descriptive of the ways in which the State or State-designated entity will carry out the activities 4. Any other elements required by the Secretary The definition of a qualified State-designated entity [subsection (f)] is one that includes all of the following criteria: (a) designated by the State; (b) a non-profit with broad stakeholder representation on its governing Board; (c) demonstrates that one of the entity's principle goals is to use IT for the improvement of quality and efficiency through secure/appropriate e-exchange of health information; and, (d) demonstrates open, fair, and non-discriminatory participatory practices; and, (e) any other requirement set forth by the Secretary. In carrying out its duties, the State or State-designated entity must consult with, and include the recommendations of a wide variety of healthcare stakeholders [subsection g] – everyone from providers, health plans, clinical researchers, other users of health IT such as clerical workers engaged in patient care coordination, health IT vendors, patient groups, public health, and colleges. The grant program is iterative [subsection h] – each year, the Secretary will evaluate the previous year's grant outcomes and make changes to the next year's program. Specifically, the Secretary is looking for opportunities towards the greatest improvement in care quality, cost reductions, and the most effective e-exchange of health information. Prior to FY11, the Secretary has the latitude to determine if a State receiving a grant must contribute a non-federal matching contribution [subsection (i)]. However, beginning in FY11, the Secretary may only make grants to States that agree to contribute such funds. The contribution can be in-kind and the schedule is as follows: FY11 – not less than $1 for each $10 of federal funds	

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to be carried out by a State or by the qualified State-designated entity within such State to facilitate and expand the electronic movement and use of health information among organizations according to nationally recognized standards and implementation specifications. `(2) REQUIRED ELEMENTS- A plan described in paragraph (1) shall-- `(A) be pursued in the public interest; `(B) be consistent with the strategic plan developed by the National Coordinator, (and, as available) under section 3001; `(C) include a description of the ways the State or qualified State-designated entity will carry out the activities described in subsection (b); and `(D) contain such elements as the Secretary may require. `(f) Qualified State-Designated Entity- For purposes of this section, to be a qualified State-designated entity, with respect to a State, an entity shall-- `(1) be designated by the State as eligible to receive awards under this section; `(2) be a not-for-profit entity with broad stakeholder representation on its governing board; `(3) demonstrate that one of its principal goals is to use information technology to improve health care quality and efficiency through the authorized and secure electronic exchange and use of health information; `(4) adopt nondiscrimination and conflict of	FY12 – not less than $1 for each $7 of federal funds FY13 and each subsequent year – not less than $1 for each $3 of federal funds.	

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interest policies that demonstrate a commitment to open, fair, and nondiscriminatory participation by stakeholders; and `(5) conform to such other requirements as the Secretary may establish. `(g) Required Consultation- In carrying out activities described in subsections (b) and (c), a State or qualified State-designated entity shall consult with and consider the recommendations of-- `(1) health care providers (including providers that provide services to low income and underserved populations); `(2) health plans; `(3) patient or consumer organizations that represent the population to be served; `(4) health information technology vendors; `(5) health care purchasers and employers; `(6) public health agencies; `(7) health professions schools, universities and colleges; `(8) clinical researchers; `(9) other users of health information technology such as the support and clerical staff of providers and others involved in the care and care coordination of patients; and `(10) such other entities, as may be determined appropriate by the Secretary. `(h) Continuous Improvement- The Secretary shall annually evaluate the activities conducted under this section and shall, in awarding grants under this section, implement the lessons learned from such evaluation in a manner so that awards made subsequent to each such evaluation are made in a manner that, in the determination of the Secretary, will lead towards the		

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greatest improvement in quality of care, decrease in costs, and the most effective authorized and secure electronic exchange of health information. `(i) Required Match- `(1) IN GENERAL- For a fiscal year (beginning with fiscal year 2011), the Secretary may not make a grant under this section to a State unless the State agrees to make available non-Federal contributions (which may include in-kind contributions) toward the costs of a grant awarded under subsection (c) in an amount equal to-- `(A) for fiscal year 2011, not less than $1 for each $10 of Federal funds provided under the grant; `(B) for fiscal year 2012, not less than $1 for each $7 of Federal funds provided under the grant; and `(C) for fiscal year 2013 and each subsequent fiscal year, not less than $1 for each $3 of Federal funds provided under the grant. `(2) AUTHORITY TO REQUIRE STATE MATCH FOR FISCAL YEARS BEFORE FISCAL YEAR 2011- For any fiscal year during the grant program under this section before fiscal year 2011, the Secretary may determine the extent to which there shall be required a non-Federal contribution from a State receiving a grant under this section.		Background date

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Section 3014 – Competitive Grants to States and Indian Tribes for the Development of Loan Programs to Facilitate the Widespread Adoption of Certified EHR Technology		
`(a) In General- The National Coordinator may award competitive grants to eligible entities for the establishment of programs for loans to health care providers to conduct the activities described in subsection (e). `(b) Eligible Entity Defined- For purposes of this subsection, the term `eligible entity' means a State or Indian tribe (as defined in the Indian Self-Determination and Education Assistance Act) that-- `(1) submits to the National Coordinator an application at such time, in such manner, and containing such information as the National Coordinator may require; `(2) submits to the National Coordinator a strategic plan in accordance with subsection (d) and provides to the National Coordinator assurances that the entity will update such plan annually in accordance with such subsection; `(3) provides assurances to the National Coordinator that the entity will establish a Loan Fund in accordance with subsection (c); `(4) provides assurances to the National Coordinator that the entity will not provide a loan from the Loan Fund to a health care provider unless the provider agrees to-- `(A) submit reports on quality measures adopted by the Federal Government (by not later than 90 days after the date on	**Loan Program for Healthcare Providers:** HIMSS supports the provision that establishes a loan program for health care providers through States and Indian Tribes. The provisions align with HIMSS' Legislative Principles concerning the need for funding to assist providers in adopting health IT. Using funds that are authorized and appropriated under this subtitle, the National Coordinator may award competitive grants to States and Indian Tribes to establish loans to help healthcare providers purchase, utilize, and train personnel to use certified EHR technology; and, to improve the secure e-exchange of health information [subsection e]. These loans are deposited into a Loan Fund [subsection (e)] and may only be used for awarding loans or loan guarantees, making reimbursements, or as a source of reserve and security for leveraged loans. The proceeds of the leveraged loans are to be deposited into a Loan Fund. The reimbursements include the ability for the Loan Fund to accept private sector contributions [subsection (g)(4)(a)]. No contributing private sector entity may specify the recipient(s). The eligible entity receiving the contribution may reimburse the private sector entity – but only up to the amount of the principal contribution. A State or Indian Tribe is considered an eligible entity [subsection (b)] if it submits an application and a strategic plan to the National Coordinator; provides assurance to the National Coordinator that the Loan Fund will be established in accordance with the Act; agrees to contribute non-federal matching funds; and, agrees to only provide loans to those healthcare providers who agree to: • Submit reports on quality to CMS, and other designees of the Secretary, within	Background date

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which such measures are adopted), to-- `(i) the Administrator of the Centers for Medicare & Medicaid Services (or his or her designee), in the case of an entity participating in the Medicare program under title XVIII of the Social Security Act or the Medicaid program under title XIX of such Act; or `(ii) the Secretary in the case of other entities; `(B) demonstrate to the satisfaction of the Secretary (through criteria established by the Secretary) that any certified EHR technology purchased, improved, or otherwise financially supported under a loan under this section is used to exchange health information in a manner that, in accordance with law and standards (as adopted under section 3004) applicable to the exchange of information, improves the quality of health care, such as promoting care coordination; and `(C) comply with such other requirements as the entity or the Secretary may require; `(D) include a plan on how health care providers involved intend to maintain and support the certified EHR technology over time; `(E) include a plan on how the health	90 days of adoption by the federal government; • Demonstrates that any item purchased under the Loan Fund meets the definition of meaningful use (e-exchange of health information, improves the quality of care such as promoting care coordination, and that the EHR technology is certified); and, • Share their plan for how they intend to maintain and support the certified EHR technology over time. As part of its plan submitted to the National Coordinator, the State or Indian Tribe must describe the annual [subsection (d)] projects to be assisted; the criteria and method for disbursing funds; the financial status of the Loan Fund; and the Loan Fund's short- and long-term goals. The money in the Loan Fund may only be used for [subsection (f)] specific purposes. For example, the interest rate charged may not exceed the market interest rate. The principal and interest payments on each loan shall commence within one year of award, and each loan must be fully amortized within 10 years of the loan's date. The Loan Fund is the only account to which principal and interest payments can be credited. The Loan Fund can also be used to guarantee, or purchase insurance for, a local obligation – for which all the proceeds must finance an eligible project – if credit market access would be improved, or if it would reduce the interest rate of the applicable obligation. Third, the Loan Fund can be used as a source of revenue or security to pay on the principal & interest on revenue or general obligation bonds issued by the eligible entity (proceeds must be deposited into the Loan Fund). Amounts deposited may also be used to earn interest, and to reimburse private-sector entities that contributed to the Loan Fund. To make administration of the Loan Fund more convenient and to avoid wasteful costs, the State or Indian Tribe may combine administrative tasks with any other revolving fund [subsection (g)(1)]. Of course, any prohibitions in State law must	

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care providers involved intend to maintain and support the certified EHR technology that would be purchased with such loan, including the type of resources expected to be involved and any such other information as the State or Indian Tribe, respectively, may require; and `(5) agrees to provide matching funds in accordance with subsection (h). `(c) Establishment of Fund- For purposes of subsection (b)(3), an eligible entity shall establish a certified EHR technology loan fund (referred to in this subsection as a `Loan Fund') and comply with the other requirements contained in this section. A grant to an eligible entity under this section shall be deposited in the Loan Fund established by the eligible entity. No funds authorized by other provisions of this title to be used for other purposes specified in this title shall be deposited in any Loan Fund. `(d) Strategic Plan- `(1) IN GENERAL- For purposes of subsection (b)(2), a strategic plan of an eligible entity under this subsection shall identify the intended uses of amounts available to the Loan Fund of such entity. `(2) CONTENTS- A strategic plan under paragraph (1), with respect to a Loan Fund of an eligible entity, shall include for a year the following: `(A) A list of the projects to be assisted through the Loan Fund during such year. `(B) A description of the criteria and	be adhered to. Administrative costs cannot exceed 4% of the federal grant funds provided [subsection (g)(2)]; and, the National Coordinator will publish guidelines and promulgate regulations to ensure appropriate use of the federal funds, and to prevent fraud, abuse, and waste [subsection (g)(3)].	

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methods established for the distribution of funds from the Loan Fund during the year. `(C) A description of the financial status of the Loan Fund as of the date of submission of the plan. `(D) The short-term and long-term goals of the Loan Fund. `(e) Use of Funds- Amounts deposited in a Loan Fund, including loan repayments and interest earned on such amounts, shall be used only for awarding loans or loan guarantees, making reimbursements described in subsection (g)(4)(A), or as a source of reserve and security for leveraged loans, the proceeds of which are deposited in the Loan Fund established under subsection (c). Loans under this section may be used by a health care provider to-- `(1) facilitate the purchase of certified EHR technology; `(2) enhance the utilization of certified EHR technology (which may include costs associated with upgrading health information technology so that it meets criteria necessary to be a certified EHR technology); `(3) train personnel in the use of such technology; or `(4) improve the secure electronic exchange of health information. `(f) Types of Assistance- Except as otherwise limited by applicable State law, amounts deposited into a Loan Fund under this section may only be used for the following: `(1) To award loans that comply with the following:		

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`(A) The interest rate for each loan shall not exceed the market interest rate. `(B) The principal and interest payments on each loan shall commence not later than 1 year after the date the loan was awarded, and each loan shall be fully amortized not later than 10 years after the date of the loan. `(C) The Loan Fund shall be credited with all payments of principal and interest on each loan awarded from the Loan Fund. `(2) To guarantee, or purchase insurance for, a local obligation (all of the proceeds of which finance a project eligible for assistance under this subsection) if the guarantee or purchase would improve credit market access or reduce the interest rate applicable to the obligation involved. `(3) As a source of revenue or security for the payment of principal and interest on revenue or general obligation bonds issued by the eligible entity if the proceeds of the sale of the bonds will be deposited into the Loan Fund. `(4) To earn interest on the amounts deposited into the Loan Fund. `(5) To make reimbursements described in subsection (g)(4)(A). `(g) Administration of Loan Funds- `(1) COMBINED FINANCIAL ADMINISTRATION- An eligible entity may (as a convenience and to avoid unnecessary administrative costs) combine, in accordance		Background date

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with applicable State law, the financial administration of a Loan Fund established under this subsection with the financial administration of any other revolving fund established by the entity if otherwise not prohibited by the law under which the Loan Fund was established. `(2) COST OF ADMINISTERING FUND- Each eligible entity may annually use not to exceed 4 percent of the funds provided to the entity under a grant under this section to pay the reasonable costs of the administration of the programs under this section, including the recovery of reasonable costs expended to establish a Loan Fund which are incurred after the date of the enactment of this title. `(3) GUIDANCE AND REGULATIONS- The National Coordinator shall publish guidance and promulgate regulations as may be necessary to carry out the provisions of this section, including-- `(A) provisions to ensure that each eligible entity commits and expends funds allotted to the entity under this section as efficiently as possible in accordance with this title and applicable State laws; and `(B) guidance to prevent waste, fraud, and abuse. `(4) PRIVATE SECTOR CONTRIBUTIONS- `(A) IN GENERAL- A Loan Fund established under this section may accept contributions from private sector entities, except that such entities may		

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not specify the recipient or recipients of any loan issued under this subsection. An eligible entity may agree to reimburse a private sector entity for any contribution made under this subparagraph, except that the amount of such reimbursement may not be greater than the principal amount of the contribution made. `(B) AVAILABILITY OF INFORMATION- An eligible entity shall make publicly available the identity of, and amount contributed by, any private sector entity under subparagraph (A) and may issue letters of commendation or make other awards (that have no financial value) to any such entity. `(h) Matching Requirements- `(1) IN GENERAL- The National Coordinator may not make a grant under subsection (a) to an eligible entity unless the entity agrees to make available (directly or through donations from public or private entities) non-Federal contributions in cash to the costs of carrying out the activities for which the grant is awarded in an amount equal to not less than $1 for each $5 of Federal funds provided under the grant. `(2) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION- In determining the amount of non-Federal contributions that an eligible entity has provided pursuant to subparagraph (A), the National Coordinator may not include any		

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amounts provided to the entity by the Federal Government. `(i) Effective Date- The Secretary may not make an award under this section prior to January 1, 2010.		01/01/2010
Section 3015 – Demonstration Program to Integrate Information Technology into Clinical Education		
`(a) In General- The Secretary may award grants under this section to carry out demonstration projects to develop academic curricula integrating certified EHR technology in the clinical education of health professionals. Such awards shall be made on a competitive basis and pursuant to peer review. `(b) Eligibility- To be eligible to receive a grant under subsection (a), an entity shall-- `(1) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require; `(2) submit to the Secretary a strategic plan for integrating certified EHR technology in the clinical education of health professionals to reduce medical errors, increase access to prevention, reduce chronic diseases, and enhance health care quality; `(3) be-- `(A) a school of medicine, osteopathic medicine, dentistry, or pharmacy, a graduate program in behavioral or mental health, or any other graduate health professions school; `(B) a graduate school of nursing or physician assistant studies; `(C) a consortium of two or more	**Demonstration Program to Develop Academic Curricula:** HIMSS supports the provision to establish a demonstration program to help integrate certified EHR technology into clinical education. To be eligible for the grants, a school or education program must adhere to a list of requirements and be a school of: • medicine, osteopathic medicine, dentistry, or pharmacy; or, • a graduate program in behavioral or mental health, or any other graduate health professional school; or, • a graduate school of nursing or physician assistant studies; or, • a consortium of two or more schools described above; or, • an institution with a graduate medical education program in medicine, osteopathic medicine, dentistry, pharmacy, nursing, or physician assistance studies. One major obstacle awaiting the healthcare industry is the dearth of workers equipped to create, implement, and optimize the use of health IT. One calculation estimates that 200,000 new jobs will be created as a result of each $10 billion in spending on EHRs and related health IT projects. These jobs include positions for training and implementation as well as health IT project management. Another study documents that 40,000 workers will be required – in the hospital market alone – to achieve desired levels of EHR functionality. It will take significant training efforts to achieve an appropriate pool of qualified workers. One shining example is the TIGER initiative, designed to enable practicing nurses and nursing students to use IT seamlessly to provide safer, higher-quality care.	

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schools described in subparagraph (A) or (B); or `(D) an institution with a graduate medical education program in medicine, osteopathic medicine, dentistry, pharmacy, nursing, or physician assistance studies; `(4) provide for the collection of data regarding the effectiveness of the demonstration project to be funded under the grant in improving the safety of patients, the efficiency of health care delivery, and in increasing the likelihood that graduates of the grantee will adopt and incorporate certified EHR technology, in the delivery of health care services; and `(5) provide matching funds in accordance with subsection (d). `(c) Use of Funds- `(1) IN GENERAL- With respect to a grant under subsection (a), an eligible entity shall-- `(A) use grant funds in collaboration with 2 or more disciplines; and `(B) use grant funds to integrate certified EHR technology into community-based clinical education. `(2) LIMITATION- An eligible entity shall not use amounts received under a grant under subsection (a) to purchase hardware, software, or services. `(d) Financial Support- The Secretary may not provide more than 50 percent of the costs of any activity for which assistance is provided under subsection (a), except in an instance of national economic conditions		

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which would render the cost-share requirement under this subsection detrimental to the program and upon notification to Congress as to the justification to waive the cost-share requirement. `(e) Evaluation- The Secretary shall take such action as may be necessary to evaluate the projects funded under this section and publish, make available, and disseminate the results of such evaluations on as wide a basis as is practicable. `(f) Reports- Not later than 1 year after the date of enactment of this title, and annually thereafter, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate, and the Committee on Energy and Commerce of the House of Representatives a report that-- `(1) describes the specific projects established under this section; and `(2) contains recommendations for Congress based on the evaluation conducted under subsection (e).		NLT 02/17/2010
Section 3016 – Information Technology Professionals on Health Care		
`(a) In General- The Secretary, in consultation with the Director of the National Science Foundation, shall provide assistance to institutions of higher education (or consortia thereof) to establish or expand medical health informatics education programs, including certification, undergraduate, and masters degree programs, for both health care and information technology students to ensure the rapid and effective utilization and development of health information	**Establishment and Expansion of Medical Health Informatics Education Program:** HIMSS supports this provision for the Secretary, in consultation with the Director of the National Science Foundation, to provide assistance to institutions of higher education to establish or expand medical health informatics education programs. As health IT replaces paper, clinicians will need education and training in all aspects of clinical informatics, not just hardware and software.	

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technologies (in the United States health care infrastructure). `(b) Activities- Activities for which assistance may be provided under subsection (a) may include the following: `(1) Developing and revising curricula in medical health informatics and related disciplines. `(2) Recruiting and retaining students to the program involved. `(3) Acquiring equipment necessary for student instruction in these programs, including the installation of testbed networks for student use. `(4) Establishing or enhancing bridge programs in the health informatics fields between community colleges and universities. `(c) Priority- In providing assistance under subsection (a), the Secretary shall give preference to the following: `(1) Existing education and training programs. `(2) Programs designed to be completed in less than six months.		
Section 3017 – General Grant and Loan Provisions		
`(a) Reports- The Secretary may require that an entity receiving assistance under this subtitle shall submit to the Secretary, not later than the date that is 1 year after the date of receipt of such assistance, a report that includes-- `(1) an analysis of the effectiveness of the activities for which the entity receives such assistance, as compared to the goals for such activities; and `(2) an analysis of the impact of the project on	**Report:** HIMSS supports the provision. Such an activity fosters necessary and appropriate oversight of an initiative.	Due Process

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health care quality and safety. `(b) Requirement to Improve Quality of Care and Decrease in Costs- The National Coordinator shall annually evaluate the activities conducted under this subtitle and shall, in awarding grants, implement the lessons learned from such evaluation in a manner so that awards made subsequent to each such evaluation are made in a manner that, in the determination of the National Coordinator, will result in the greatest improvement in the quality and efficiency of health care.		
Section 3018 – Authorization for Appropriations		
For purposes of carrying out this subtitle, there is authorized to be appropriated such sums as may be necessary for each of the fiscal years 2009 through 2013. Amounts so appropriated shall remain available until expended.	**Authorization and Appropriation of Funding:** HIMSS supports these provisions.	Background date
Subtitle D – Privacy **Part 1 – Improved Privacy Provisions and Security Provisions**		
Section 13401 – Application of Security provisions and penalties to business associated of covered entities; annual guidance on security provisions		

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(a) Application of Security Provisions.--Sections 164.308, 164.310, 164.312, and 164.316 of title 45, Code of Federal Regulations, shall apply to a business associate of a covered entity in the same manner that such sections apply to the covered entity. The additional requirements of this title that relate to security and that are made applicable with respect to covered entities shall also be applicable to such a business associate and shall be incorporated into the business associate agreement between the business associate and the covered entity. (b) Application of Civil and Criminal Penalties.--In the case of a business associate that violates any security provision specified in subsection (a), sections 1176 and 1177 of the Social Security Act (42 U.S.C. 1320d-5, 1320d-6) shall apply to the business associate with respect to such violation in the same manner such sections apply to a covered entity that violates such security provision. (c) Annual Guidance.--For the first year beginning after the date of the enactment of this Act and annually thereafter, the Secretary of Health and Human Services shall, after consultation with stakeholders, annually issue guidance on the most effective and appropriate technical safeguards for use in carrying out the sections referred to in subsection (a) and the security standards in subpart C of part 164 of title 45, Code of Federal Regulations, including the use of standards developed under section 3002(b)(2)(B)(vi) of the Public Health Service Act, as added by section 13101 of this Act, as such provisions are in effect as of the date before the enactment of this Act.	**Application of Security Provisions:** HIMSS supports this provision	02/17/2010 Annual Thereafter

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Section 13402 – Notification in the Case of Breach		
(a) In General.--A covered entity that accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses unsecured protected health information (as defined in subsection (h)(1)) shall, in the case of a breach of such information that is discovered by the covered entity, notify each individual whose unsecured protected health information has been, or is reasonably believed by the covered entity to have been, accessed, acquired, or disclosed as a result of such breach. (b) Notification of Covered Entity by Business Associate.--A business associate of a covered entity that accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses unsecured protected health information shall, following the discovery of a breach of such information, notify the covered entity of such breach. Such notice shall include the identification of each individual whose unsecured protected health information has been, or is reasonably believed by the business associate to have been, accessed, acquired, or disclosed during such breach. (c) Breaches Treated as Discovered.--For purposes of this section, a breach shall be treated as discovered by a covered entity or by a business associate as of the first day on which such breach is known to such entity or associate, respectively, (including any person, other than the individual committing the breach, that is an	**Notification in the Case of a Breach:** HIMSS supports the notification of individuals whose information may have been compromised. However, • HIMSS does not support a requirement for a broad, public notification of a potential breach, as this increases overall security risk. • Further, HIMSS believes that breach notification provisions should consider/be triggered by the risk of harm that may result from the disclosure, as opposed to merely the number of records breached. Redundant notifications or notifications where there is little possibility of further harm would only confuse and worry patients. HIMSS expresses concern that the Act may result in confusion regarding notification responsibilities among Covered Entities and Business Associates in Health Information Exchange scenarios, potentially resulting in redundant/confusing notifications to patients.	

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employee, officer, or other agent of such entity or associate, respectively) or should reasonably have been known to such entity or associate (or person) to have occurred. (d) Timeliness of Notification.-- (1) IN GENERAL.--Subject to subsection (g), all notifications required under this section shall be made without unreasonable delay and in no case later than 60 calendar days after the discovery of a breach by the covered entity involved (or business associate involved in the case of a notification required under subsection (b)). (2) BURDEN OF PROOF.--The covered entity involved (or business associate involved in the case of a notification required under subsection (b)), shall have the burden of demonstrating that all notifications were made as required under this part, including evidence demonstrating the necessity of any delay. (e) Methods of Notice.-- (1) INDIVIDUAL NOTICE.--Notice required under this section to be provided to an individual, with respect to a breach, shall be provided promptly and in the following form: (A) Written notification by first-class mail to the individual (or the next of kin of the individual if the individual is deceased) at the last known address of the individual or the next of kin, respectively, or, if specified as a preference by the individual, by electronic mail. The notification may be provided in one or more		Background date

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mailings as information is available. (B) In the case in which there is insufficient, or out-of-date contact information (including a phone number, email address, or any other form of appropriate communication) that precludes direct written (or, if specified by the individual under subparagraph (A), electronic) notification to the individual, a substitute form of notice shall be provided, including, in the case that there are 10 or more individuals for which there is insufficient or out-of-date contact information, a conspicuous posting for a period determined by the Secretary on the home page of the Web site of the covered entity involved or notice in major print or broadcast media, including major media in geographic areas where the individuals affected by the breach likely reside. Such a notice in media or web posting will include a toll-free phone number where an individual can learn whether or not the individual's unsecured protected health information is possibly included in the breach. (C) In any case deemed by the covered entity involved to require urgency because of possible imminent misuse of unsecured protected health information, the covered entity, in addition to notice provided under subparagraph (A), may provide information to individuals by telephone or other means, as appropriate. (2) MEDIA NOTICE.--Notice shall be provided to prominent media outlets serving a State or jurisdiction, following the discovery of a breach described in subsection (a), if the unsecured protected health		

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information of more than 500 residents of such State or jurisdiction is, or is reasonably believed to have been, accessed, acquired, or disclosed during such breach. (3) NOTICE TO SECRETARY.--Notice shall be provided to the Secretary by covered entities of unsecured protected health information that has been acquired or disclosed in a breach. If the breach was with respect to 500 or more individuals than such notice must be provided immediately. If the breach was with respect to less than 500 individuals, the covered entity may maintain a log of any such breach occurring and annually submit such a log to the Secretary documenting such breaches occurring during the year involved. (4) POSTING ON HHS PUBLIC WEBSITE.--The Secretary shall make available to the public on the Internet website of the Department of Health and Human Services a list that identifies each covered entity involved in a breach described in subsection (a) in which the unsecured protected health information of more than 500 individuals is acquired or disclosed. (f) Content of Notification.--Regardless of the method by which notice is provided to individuals under this section, notice of a breach shall include, to the extent possible, the following: (1) A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known. (2) A description of the types of unsecured protected		

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health information that were involved in the breach (such as full name, Social Security number, date of birth, home address, account number, or disability code). (3) The steps individuals should take to protect themselves from potential harm resulting from the breach. (4) A brief description of what the covered entity involved is doing to investigate the breach, to mitigate losses, and to protect against any further breaches. (5) Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, Web site, or postal address. (g) Delay of Notification Authorized for Law Enforcement Purposes.--If a law enforcement official determines that a notification, notice, or posting required under this section would impede a criminal investigation or cause damage to national security, such notification, notice, or posting shall be delayed in the same manner as provided under section 164.528(a)(2) of title 45, Code of Federal Regulations, in the case of a disclosure covered under such section. (h) Unsecured Protected Health Information.-- (1) DEFINITION.-- (A) IN GENERAL.--Subject to subparagraph (B), for purposes of this section, the term ``unsecured protected		

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health information" means protected health information that is not secured through the use of a technology or methodology specified by the Secretary in the guidance issued under paragraph (2). (B) EXCEPTION IN CASE TIMELY GUIDANCE NOT ISSUED.--In the case that the Secretary does not issue guidance under paragraph (2) by the date specified in such paragraph, for purposes of this section, the term ``unsecured protected health information'' shall mean protected health information that is not secured by a technology standard that renders protected health information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute. (2) GUIDANCE.--For purposes of paragraph (1) and section 13407(f)(3), not later than the date that is 60 days after the date of the enactment of this Act, the Secretary shall, after consultation with stakeholders, issue (and annually update) guidance specifying the technologies and methodologies that render protected health information unusable, unreadable, or indecipherable to unauthorized individuals, including the use of standards developed under section 3002(b)(2)(B)(vi) of the Public Health Service Act, as added by section 13101 of this Act. (i) Report to Congress on Breaches.-- (1) IN GENERAL.--Not later than 12 months after the date of the enactment of this Act and annually		04/18/2009 02/17/2010 Annually Thereafter

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thereafter, the Secretary shall prepare and submit to the Committee on Finance and the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report containing the information described in paragraph (2) regarding breaches for which notice was provided to the Secretary under subsection (e)(3). (2) INFORMATION.--The information described in this paragraph regarding breaches specified in paragraph (1) shall include-- (A) the number and nature of such breaches; and (B) actions taken in response to such breaches. (j) Regulations; Effective Date.--To carry out this section, the Secretary of Health and Human Services shall promulgate interim final regulations by not later than the date that is 180 days after the date of the enactment of this title. The provisions of this section shall apply to breaches that are discovered on or after the date that is 30 days after the date of publication of such interim final regulations.		NLT 08/17/2009 Background date
Section 13402 – Education on Health Information Privacy		
(a) Regional Office Privacy Advisors.--Not later than 6 months after the date of the enactment of this Act, the Secretary shall designate an individual in each regional office of the Department of Health and Human Services to offer guidance and education to covered entities, business associates, and individuals on their rights and	**Education:** HIMSS supports the provisions to establish regional office privacy advisors that are to be located in regional HHS offices. HIMSS also support the establishment of an education initiative on the appropriate uses of health information. Such activities will help ensure that all stakeholders have accesses to credible and timely information concerning the handling of protected health information. HIMSS can connect the privacy officers with our chapters across the	NLT 08/17/2009

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responsibilities related to Federal privacy and security requirements for protected health information. (b) Education Initiative on Uses of Health Information.--Not later than 12 months after the date of the enactment of this Act, the Office for Civil Rights within the Department of Health and Human Services shall develop and maintain a multi-faceted national education initiative to enhance public transparency regarding the uses of protected health information, including programs to educate individuals about the potential uses of their protected health information, the effects of such uses, and the rights of individuals with respect to such uses. Such programs shall be conducted in a variety of languages and present information in a clear and understandable manner.	nation, thereby enabling enhanced access for the privacy advisors to regionally-based healthcare settings.	NLT 02/17/2010
Section 13404 – Application of Privacy Provisions and Penalties to Business Associates of Covered Entities		
(a) Application of Contract Requirements.--In the case of a business associate of a covered entity that obtains or creates protected health information pursuant to a written contract (or other written arrangement) described in section 164.502(e)(2) of title 45, Code of Federal Regulations, with such covered entity, the business associate may use and disclose such protected health information only if such use or disclosure, respectively, is in compliance with each applicable requirement of section 164.504(e) of such title. The additional requirements of this subtitle that relate to privacy and that are made applicable with respect to covered entities shall also be applicable to such a business associate and shall be incorporated into the business associate agreement between the business	**Application of Privacy Provisions and Penalties to Business Associates of Covered Entities:** HIMSS supports the provision to apply the privacy provisions as directed by HIPAA and the legislation to business associates and covered entities. HIMSS notes that the provision is likely to increase the cost of doing business, but is probably a minimum necessary in terms of enhanced enforcement.	

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associate and the covered entity. (b) Application of Knowledge Elements Associated With Contracts.--Section 164.504(e)(1)(ii) of title 45, Code of Federal Regulations, shall apply to a business associate described in subsection (a), with respect to compliance with such subsection, in the same manner that such section applies to a covered entity, with respect to compliance with the standards in sections 164.502(e) and 164.504(e) of such title, except that in applying such section 164.504(e)(1)(ii) each reference to the business associate, with respect to a contract, shall be treated as a reference to the covered entity involved in such contract. (c) Application of Civil and Criminal Penalties.--In the case of a business associate that violates any provision of subsection (a) or (b), the provisions of sections 1176 and 1177 of the Social Security Act (42 U.S.C. 1320d-5, 1320d-6) shall apply to the business associate with respect to such violation in the same manner as such provisions apply to a person who violates a provision of part C of title XI of such Act.		
Section 13405 – Restrictions on Certain Disclosures and Sales of Health Information; Accounting of Certain Protected Health Information Disclosures; Access to Certain Information in Electronic Format		
(a) Requested Restrictions on Certain **Disclosures of Health Information**.--In the case that an individual requests under paragraph (a)(1)(i)(A) of section 164.522 of title 45, Code of Federal Regulations, that a covered entity restrict the disclosure of the protected health	**Accounting of Disclosures**: HIMSS supports this provision in principle, but recognizes that technology and operational practices in use today may not allow CES to immediately meet this requirement. Therefore, HIMSS recommends that this provision be limited to disclosures of structured information, and that its	

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information of the individual, notwithstanding paragraph (a)(1)(ii) of such section, the covered entity must comply with the requested restriction if-- (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. (b) Disclosures Required To Be Limited to the Limited Data Set or the Minimum Necessary.-- (1) IN GENERAL.-- (A) IN GENERAL.--Subject to subparagraph (B), a covered entity shall be treated as being in compliance with section 164.502(b)(1) of title 45, Code of Federal Regulations, with respect to the use, disclosure, or request of protected health information described in such section, only if the covered entity limits such protected health information, to the extent practicable, to the limited data set (as defined in section 164.514(e)(2) of such title) or, if needed by such entity, to the minimum necessary to accomplish the intended purpose of such use, disclosure, or request, respectively. (B) GUIDANCE.--Not later than 18 months after the date of the enactment of this section, the Secretary shall issue guidance on what constitutes ``minimum necessary'' for purposes of subpart E of part 164 of title 45, Code of Federal Regulation. In issuing such guidance the Secretary shall take into consideration the	implementation be tied to health IT product certification efforts to enable it to be implemented as supporting technology becomes available, and so as to avoid significant cost and operational disruption to the current health system. We recognize that this legislation directs the Secretary of HHS to consider what types of technologies are available and feasible for improving privacy and security that can be built into technical standards and that it establishes an implementation timeline. We believe these types of approaches ultimately will create more valuable information for patients and allow health care organizations to devote more resources to the delivery of care. We note the following complexities due to the current language in the Act: - Identifying a "disclosure", as defined by the legislation, within treatment and healthcare operations will need new interpretations. For example, within a hospital setting a communication to a non-employee who has privileges (a contractor) is a disclosure, when the same communication to an employed doctor is not. Therefore, CEs will likely be required to spend time sorting out what is a disclosure as opposed to what is considered an internal communication. - The definition of an EHR provided in the legislation is: "an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff within a single organization." This definition is extremely broad and could be interpreted to cover a simple e-mail, faxes and/or many other independent forms of recordkeeping – patient safety, internal billing, e-prescribing, databases, etc. **Sale:** HIMSS has residual concerns regarding these provisions, as they add complexities and burdens that could undermine quality improvement, patient safety and delivery of care. These complexities include, but may not be limited to, the definition of "sale," purposes of the sale; definition of an "individual's health information" (e.g., de-identified vs. identifiable); property and ownership issues, etc.	NLT 08/17/2010

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guidance under section 13424(c) and the information necessary to improve patient outcomes and to detect, prevent, and manage chronic disease. (C) SUNSET.--Subparagraph (A) shall not apply on and after the effective date on which the Secretary issues the guidance under subparagraph (B). (2) DETERMINATION OF MINIMUM NECESSARY.--For purposes of paragraph (1), in the case of the disclosure of protected health information, the covered entity or business associate disclosing such information shall determine what constitutes the minimum necessary to accomplish the intended purpose of such disclosure. (3) APPLICATION OF EXCEPTIONS.--The exceptions described in section 164.502(b)(2) of title 45, Code of Federal Regulations, shall apply to the requirement under paragraph (1) as of the effective date described in section 13423 in the same manner that such exceptions apply to section 164.502(b)(1) of such title before such date. (4) RULE OF CONSTRUCTION.--Nothing in this subsection shall be construed as affecting the use, disclosure, or request of protected health information that has been de-identified. (c) Accounting of Certain Protected Health Information Disclosures Required if Covered Entity Uses Electronic Health Record.-- ``(1) IN GENERAL.--In applying section 164.528 of	The prohibition applies to "direct or indirect remuneration" in exchange for any information unless there is consent or authorization. The final stimulus bill allows remuneration in cases of research but only limited to costs of preparing and transmitting data. As an example in the area of research, many parties provide access to databases for research at a price. The current price reflects the value of the database, *not* the cost of transmittal. This means the financial arrangements for many research, drug safety, surveillance and other useful activities would no longer be permissible. Also, the burden of the individual consent requirements could undercut the value of these activities. The final bill permits the sale of protected health information for public health activities. The Secretary is required to study and determine whether costs should be limited. HIMSS feels this is an improved approach.	Background date

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title 45, Code of Federal Regulations, in the case that a covered entity uses or maintains an electronic health record with respect to protected health information-- ``(A) the exception under paragraph (a)(1)(i) of such section shall not apply to disclosures through an electronic health record made by such entity of such information; and  ``(B) an individual shall have a right to receive an accounting of disclosures described in such paragraph of such information made by such covered entity during only the three years prior to the date on which the accounting is requested. ``(2) REGULATIONS.--The Secretary shall promulgate regulations on what information shall be collected about each disclosure referred to in paragraph (1), not later than 6 months after the date on which the Secretary adopts standards on accounting for disclosure described in the section 3002(b)(2)(B)(iv) of the Public Health Service Act, as added by section 13101. Such regulations shall only require such information to be collected through an electronic health record in a manner that takes into account the interests of the individuals in learning the circumstances under which their protected health information is being disclosed and takes into account the administrative burden of accounting for such disclosures. ``(3) PROCESS.--In response to an request from an individual for an accounting, a covered entity shall elect to provide either an--		Background date Due Process

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``(A) accounting, as specified under paragraph (1), for disclosures of protected health information that are made by such covered entity and by a business associate acting on behalf of the covered entity; or  ``(B) accounting, as specified under paragraph (1), for disclosures that are made by such covered entity and provide a list of all business associates acting on behalf of the covered entity, including contact information for such associates (such as mailing address, phone, and email address). A business associate included on a list under subparagraph (B) shall provide an accounting of disclosures (as required under paragraph (1) for a covered entity) made by the business associate upon a request made by an individual directly to the business associate for such an accounting. ``(4) EFFECTIVE DATE.--  ``(A) CURRENT USERS OF ELECTRONIC RECORDS.--In the case of a covered entity insofar as it acquired an electronic health record as of January 1, 2009, paragraph (1) shall apply to disclosures, with respect to protected health information, made by the covered entity from such a record on and after January 1, 2014. ``(B) OTHERS.--In the case of a covered entity insofar as it acquires an electronic health record after January 1, 2009, paragraph (1) shall apply to disclosures, with respect to protected health information, made by the covered entity from such		Background date Background date Background

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record on and after the later of the following: ``(i) January 1, 2011; or  ``(ii) the date that it acquires an electronic health record. ``(C) LATER DATE.--The Secretary may set an effective date that is later that the date specified under subparagraph (A) or (B) if the Secretary determines that such later date is necessary, but in no case may the date specified under--  ``(i) subparagraph (A) be later than 2016; or ``(ii) subparagraph (B) be later than 2013." (d) Prohibition on **Sale** of Electronic Health Records or Protected Health Information.-- (1) IN GENERAL.--Except as provided in paragraph (2), a covered entity or business associate shall not directly or indirectly receive remuneration in exchange for any protected health information of an individual unless the covered entity obtained from the individual, in accordance with section 164.508 of title 45, Code of Federal Regulations, a valid authorization that includes, in accordance with such section, a specification of whether the protected health information can be further exchanged for remuneration by the entity receiving protected health information of that individual. (2) EXCEPTIONS.--Paragraph (1) shall not apply in the following cases:		date Background date

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(A) The purpose of the exchange is for public health activities (as described in section 164.512(b) of title 45, Code of Federal Regulations). (B) The purpose of the exchange is for research (as described in sections 164.501 and 164.512(i) of title 45, Code of Federal Regulations) and the price charged reflects the costs of preparation and transmittal of the data for such purpose. (C) The purpose of the exchange is for the treatment of the individual, subject to any regulation that the Secretary may promulgate to prevent protected health information from inappropriate access, use, or disclosure. (D) The purpose of the exchange is the health care operation specifically described in subparagraph (iv) of paragraph (6) of the definition of healthcare operations in section 164.501 of title 45, Code of Federal Regulations. (E) The purpose of the exchange is for remuneration that is provided by a covered entity to a business associate for activities involving the exchange of protected health information that the business associate undertakes on behalf of and at the specific request of the covered entity pursuant to a business associate agreement. (F) The purpose of the exchange is to provide an individual with a copy of the individual's protected health information pursuant to section 164.524 of title		

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45, Code of Federal Regulations. (G) The purpose of the exchange is otherwise determined by the Secretary in regulations to be similarly necessary and appropriate as the exceptions provided in subparagraphs (A) through (F). (3) REGULATIONS.--Not later than 18 months after the date of enactment of this title, the Secretary shall promulgate regulations to carry out this subsection. In promulgating such regulations, the Secretary-- (A) shall evaluate the impact of restricting the exception described in paragraph (2)(A) to require that the price charged for the purposes described in such paragraph reflects the costs of the preparation and transmittal of the data for such purpose, on research or public health activities, including those conducted by or for the use of the Food and Drug Administration; and (B) may further restrict the exception described in paragraph (2)(A) to require that the price charged for the purposes described in such paragraph reflects the costs of the preparation and transmittal of the data for such purpose, if the Secretary finds that such further restriction will not impede such research or public health activities. (4) EFFECTIVE DATE.--Paragraph (1) shall apply to exchanges occurring on or after the date that is 6 months after the date of the promulgation of final regulations implementing this subsection. (e) Access to Certain Information in Electronic		NLT 08/17/2010 08/17/2009

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Format.--In applying section 164.524 of title 45, Code of Federal Regulations, in the case that a covered entity uses or maintains an electronic health record with respect to protected health information of an individual- (1) the individual shall have a right to obtain from such covered entity a copy of such information in an electronic format and, if the individual chooses, to direct the covered entity to transmit such copy directly to an entity or person designated by the individual, provided that any such choice is clear, conspicuous, and specific; and (2) notwithstanding paragraph (c)(4) of such section, any fee that the covered entity may impose for providing such individual with a copy of such information (or a summary or explanation of such information) if such copy (or summary or explanation) is in an electronic form shall not be greater than the entity's labor costs in responding to the request for the copy (or summary or explanation).		
Section 13406 – Conditions on Certain Contacts as Part of Health Care Operations		
(1) IN GENERAL.--A communication by a covered entity or business associate that is about a product or service and that encourages recipients of the communication to purchase or use the product or service shall not be considered a health care operation for purposes of subpart E of part 164 of title 45, Code of Federal Regulations, unless the communication is made as described in subparagraph (i), (ii), or (iii) of paragraph (1) of the definition of marketing in section 164.501 of such title. (2) PAYMENT FOR CERTAIN	**Conditions on Certain Contacts:** HIMSS is concerned about making changes to the current definition of marketing as it relates to healthcare operations as defined in HIPAA. However, HIMSS notes that the final stimulus bill makes an exception that allows providers to be paid reasonable fees, as determined by the Secretary, to make a communication to their patients about a drug or biologic that the patient is currently prescribed. HIMSS feels this is an improved approach. HIMSS assumes that during the study process, there will be opportunities for public input.	2/17/2010

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COMMUNICATIONS.--A communication by a covered entity or business associate that is described in subparagraph (i), (ii), or (iii) of paragraph (1) of the definition of marketing in section 164.501 of title 45, Code of Federal Regulations, shall not be considered a health care operation for purposes of subpart E of part 164 of title 45, Code of Federal Regulations if the covered entity receives or has received direct or indirect payment in exchange for making such communication, except where-- (A)(i) such communication describes only a drug or biologic that is currently being prescribed for the recipient of the communication; and (ii) any payment received by such covered entity in exchange for making a communication described in clause (i) is reasonable in amount; (B) each of the following conditions apply-- (i) the communication is made by the covered entity; and (ii) the covered entity making such communication obtains from the recipient of the communication, in accordance with section 164.508 of title 45, Code of Federal Regulations, a valid authorization (as described in paragraph (b) of such section) with respect to such communication; or (C) each of the following conditions apply-- (i) the communication is made by a business		

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associate on behalf of the covered entity; and (ii) the communication is consistent with the written contract (or other written arrangement described in section 164.502(e)(2) of such title) between such business associate and covered entity. (3) REASONABLE IN AMOUNT DEFINED.--For purposes of paragraph (2), the term ``reasonable in amount'' shall have the meaning given such term by the Secretary by regulation.  (4) DIRECT OR INDIRECT PAYMENT.--For purposes of paragraph (2), the term ``direct or indirect payment'' shall not include any payment for treatment (as defined in section 164.501 of title 45, Code of Federal Regulations) of an individual. (b) Opportunity to Opt Out of Fundraising.--The Secretary shall by rule provide that any written fundraising communication that is a healthcare operation as defined under section 164.501 of title 45, Code of Federal Regulations, shall, in a clear and conspicuous manner, provide an opportunity for the recipient of the communications to elect not to receive any further such communication. When an individual elects not to receive any further such communication, such election shall be treated as a revocation of authorization under section 164.508 of title 45, Code of Federal Regulations. (c) Effective Date.--This section shall apply to written communications occurring on or after the effective date specified under section 13423.		

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Section 13407: Temporary Breach Notification Requirement for Vendors and of Personal Health Records and Other Non-HIPAA Covered Entities		
(a) In General.--In accordance with subsection (c), each vendor of personal health records, following the discovery of a breach of security of unsecured PHR identifiable health information that is in a personal health record maintained or offered by such vendor, and each entity described in clause (ii), (iii), or (iv) of section 13424(b)(1)(A), following the discovery of a breach of security of such information that is obtained through a product or service provided by such entity, shall-- (1) notify each individual who is a citizen or resident of the United States whose unsecured PHR identifiable health information was acquired by an unauthorized person as a result of such a breach of security; and (2) notify the Federal Trade Commission. (b) Notification by Third Party Service Providers.--A third party service provider that provides services to a vendor of personal health records or to an entity described in clause (ii), (iii). or (iv) of section 13424(b)(1)(A) in connection with the offering or maintenance of a personal health record or a related product or service and that accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses unsecured PHR identifiable health information in such a record as a result of such services	**Temporary Breach Notification Requirement for Vendors of Personal Health Records and other non-HIPAA Covered Entities:** HIMSS supports application of the security breach notification requirements to personal health record vendors. HIMSS notes that it has the same concerns with the Temporary Breach Provisions here as with the General Breach Notification Section (see Section 13402).	

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shall, following the discovery of a breach of security of such information, notify such vendor or entity, respectively, of such breach. Such notice shall include the identification of each individual whose unsecured PHR identifiable health information has been, or is reasonably believed to have been, accessed, acquired, or disclosed during such breach. (c) Application of Requirements for Timeliness, Method, and Content of Notifications.--Subsections (c), (d), (e), and (f) of section 13402 shall apply to a notification required under subsection (a) and a vendor of personal health records, an entity described in subsection (a) and a third party service provider described in subsection (b), with respect to a breach of security under subsection (a) of unsecured PHR identifiable health information in such records maintained or offered by such vendor, in a manner specified by the Federal Trade Commission. (d) Notification of the Secretary.--Upon receipt of a notification of a breach of security under subsection (a)(2), the Federal Trade Commission shall notify the Secretary of such breach. (e) Enforcement.--A violation of subsection (a) or (b) shall be treated as an unfair and deceptive act or practice in violation of a regulation under section 18(a)(1)(B) of the Federal Trade Commission Act (15 U.S.C. 57a(a)(1)(B)) regarding unfair or deceptive acts or practices. (f) Definitions.--For purposes of this section:		

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(1) BREACH OF SECURITY.--The term ``breach of security'' means, with respect to unsecured PHR identifiable health information of an individual in a personal health record, acquisition of such information without the authorization of the individual.  (2) PHR IDENTIFIABLE HEALTH INFORMATION.--The term ``PHR identifiable health information'' means individually identifiable health information, as defined in section 1171(6) of the Social Security Act (42 U.S.C. 1320d(6)), and includes, with respect to an individual, information-- (A) that is provided by or on behalf of the individual; and (B) that identifies the individual or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. (3) UNSECURED PHR IDENTIFIABLE HEALTH INFORMATION.-- (A) IN GENERAL.--Subject to subparagraph (B), the term ``unsecured PHR identifiable health information'' means PHR identifiable health information that is not protected through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2). (B) EXCEPTION IN CASE TIMELY GUIDANCE NOT ISSUED.--In the case that the Secretary does not issue guidance under section 13402(h)(2) by the date specified in such section, for purposes of this section,		

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the term ``unsecured PHR identifiable health information'' shall mean PHR identifiable health information that is not secured by a technology standard that renders protected health information unusable, unreadable, or indecipherable to unauthorized individuals and that is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute. (g) Regulations; Effective Date; Sunset.-- (1) REGULATIONS; EFFECTIVE DATE.--To carry out this section, the Federal Trade Commission shall promulgate interim final regulations by not later than the date that is 180 days after the date of the enactment of this section. The provisions of this section shall apply to breaches of security that are discovered on or after the date that is 30 days after the date of publication of such interim final regulations. (2) SUNSET.--If Congress enacts new legislation establishing requirements for notification in the case of a breach of security, that apply to entities that are not covered entities or business associates, the provisions of this section shall not apply to breaches of security discovered on or after the effective date of regulations implementing such legislation.		NLT 08/16/2009 30-Days from above date - 09/15/2009
Section – 13408 – Business Associate Contracts Required for Certain Entities		
Each organization, with respect to a covered entity, that provides data transmission of protected health information to such entity (or its business associate) and that requires access on a routine basis to such protected health information, such as a Health Information	**Business Associate Contracts:** HIMSS supports this provision that requires such entities as health information exchange organizations and regional health information organizations that contracts with covered entities to operate as business associates. This will strengthen privacy and security measures for health information.	02/17/2010

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Exchange Organization, Regional Health Information Organization, E-prescribing Gateway, or each vendor that contracts with a covered entity to allow that covered entity to offer a personal health record to patients as part of its electronic health record, is required to enter into a written contract (or other written arrangement) described in section 164.502(e)(2) of title 45, Code of Federal Regulations and a written contract (or other arrangement) described in section 164.308(b) of such title, with such entity and shall be treated as a business associate of the covered entity for purposes of the provisions of this subtitle and subparts C and E of part 164 of title 45, Code of Federal Regulations, as such provisions are in effect as of the date of enactment of this title.		
Section 13409 – Clarification of Application of Wrongful Disclosures Criminal Penalties		
Section 1177(a) of the Social Security Act (42 U.S.C. 1320d-6(a)) is amended by adding at the end the following new sentence: ``For purposes of the previous sentence, a person (including an employee or other individual) shall be considered to have obtained or disclosed individually identifiable health information in violation of this part if the information is maintained by a covered entity (as defined in the HIPAA privacy regulation described in section 1180(b)(3)) and the individual obtained or disclosed such information without authorization."	**Wrongful Disclosures of Health Information:** HIMSS supports this provision. This will strengthen privacy and security measures for health information.	02/17/2010
Section 13410 – Improved Enforcement		
``(c) Noncompliance Due to Willful Neglect.--  ``(1) IN GENERAL.--A violation of a provision of this part due to willful neglect is a violation for which the Secretary is required to impose a penalty under	**State Attorneys Generals:** HIMSS opposes giving State Attorneys General the ability to bring civil action as a means of enforcing the HIPAA Privacy Rule. To substantiate our opposition, HIMSS submits the following: - Political pressures can influence litigation by an elected official such as a State Attorney General.	

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subsection (a)(1). ``(2) REQUIRED INVESTIGATION.--For purposes of paragraph (1), the Secretary shall formally investigate any complaint of a violation of a provision of this part if a preliminary investigation of the facts of the complaint indicate such a possible violation due to willful neglect.". (2) ENFORCEMENT UNDER SOCIAL SECURITY ACT.--Any violation by a covered entity under thus subtitle is subject to enforcement and penalties under section 1176 and 1177 of the Social Security Act. (b) Effective Date; Regulations. (1) The amendments made by subsection (a) shall apply to penalties imposed on or after the date that is 24 months after the date of the enactment of this title. (2) Not later than 18 months after the date of the enactment of this title, the Secretary of Health and Human Services shall promulgate regulations to implement such amendments. (c) Distribution of Certain Civil Monetary Penalties Collected.-- (1) IN GENERAL.--Subject to the regulation promulgated pursuant to paragraph (3), any civil monetary penalty or monetary settlement collected with respect to an offense punishable under this subtitle or section 1176 of the Social Security Act (42 U.S.C. 1320d-5) insofar as such section relates to privacy or	- The Department of Justice and the Department of Health and Human Services Office for Civil Rights (OCR) already has substantial authority to pursue criminal and civil enforcement of the HIPAA rules. Sufficient resources should be made available to OCR to maintain this capability. - OCR is subject to procedural limitations on the abuse of prosecutorial powers that would not necessarily apply to State Attorneys General. - State Attorneys General already have sufficient authority, under existing law, to enforce stricter state laws regarding the misuse of personal health information and prosecute against unfair and deceptive practices. In the event they uncover information related to suspected HIPAA violations, they may refer that information to OCR.	02/17/2011 NLT 08/17/2010

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security shall be transferred to the Office for Civil Rights of the Department of Health and Human Services to be used for purposes of enforcing the provisions of this subtitle and subparts C and E of part 164 of title 45, Code of Federal Regulations, as such provisions are in effect as of the date of enactment of this Act. (2) GAO REPORT.--Not later than 18 months after the date of the enactment of this title, the Comptroller General shall submit to the Secretary a report including recommendations for a methodology under which an individual who is harmed by an act that constitutes an offense referred to in paragraph (1) may receive a percentage of any civil monetary penalty or monetary settlement collected with respect to such offense. (3) ESTABLISHMENT OF METHODOLOGY TO DISTRIBUTE PERCENTAGE OF CMPS COLLECTED TO HARMED INDIVIDUALS.--Not later than 3 years after the date of the enactment of this title, the Secretary shall establish by regulation and based on the recommendations submitted under paragraph (2), a methodology under which an individual who is harmed by an act that constitutes an offense referred to in paragraph (1) may receive a percentage of any civil monetary penalty or monetary settlement collected with respect to such offense. (4) APPLICATION OF METHODOLOGY.--The methodology under paragraph (3) shall be applied with respect to civil monetary penalties or monetary settlements imposed on or after the effective date of the regulation.		NLT 08/17/2010 NLT 02/17/2012

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(d) Tiered Increase in Amount of Civil Monetary Penalties.-- (1) IN GENERAL.--Section 1176(a)(1) of the Social Security Act (42 U.S.C. 1320d-5(a)(1)) is amended by striking ``who violates a provision of this part a penalty of not more than'' and all that follows and inserting the following: ``who violates a provision of this part-- ``(A) in the case of a violation of such provision in which it is established that the person did not know (and by exercising reasonable diligence would not have known) that such person violated such provision, a penalty for each such violation of an amount that is at least the amount described in paragraph (3)(A) but not to exceed the amount described in paragraph (3)(D); ``(B) in the case of a violation of such provision in which it is established that the violation was due to reasonable cause and not to willful neglect, a penalty for each such violation of an amount that is at least the amount described in paragraph (3)(B) but not to exceed the amount described in paragraph (3)(D); and ``(C) in the case of a violation of such provision in which it is established that the violation was due to willful neglect--  ``(i) if the violation is corrected as described in subsection (b)(3)(A), a penalty in an amount that is at least the amount described in paragraph (3)(C) but not to exceed the amount described in paragraph (3)(D); and		

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``(ii) if the violation is not corrected as described in such subsection, a penalty in an amount that is at least the amount described in paragraph (3)(D). In determining the amount of a penalty under this section for a violation, the Secretary shall base such determination on the nature and extent of the violation and the nature and extent of the harm resulting from such violation.". (2) TIERS OF PENALTIES DESCRIBED.--Section 1176(a) of such Act (42 U.S.C. 1320d-5(a)) is further amended by adding at the end the following new paragraph: ``(3) TIERS OF PENALTIES DESCRIBED.--For purposes of paragraph (1), with respect to a violation by a person of a provision of this part--  ``(A) the amount described in this subparagraph is $100 for each such violation, except that the total amount imposed on the person for all such violations of an identical requirement or prohibition during a calendar year may not exceed $25,000; ``(B) the amount described in this subparagraph is $1,000 for each such violation, except that the total amount imposed on the person for all such violations of an identical requirement or prohibition during a calendar year may not exceed $100,000;  ``(C) the amount described in this subparagraph is $10,000 for each such violation, except that the total		

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amount imposed on the person for all such violations of an identical requirement or prohibition during a calendar year may not exceed $250,000; and ``(D) the amount described in this subparagraph is $50,000 for each such violation, except that the total amount imposed on the person for all such violations of an identical requirement or prohibition during a calendar year may not exceed $1,500,000.". (3) CONFORMING AMENDMENTS.--Section 1176(b) of such Act (42 U.S.C. 1320d-5(b)) is amended-- (A) by striking paragraph (2) and redesignating paragraphs (3) and (4) as paragraphs (2) and (3), respectively; and (B) in paragraph (2), as so redesignated-- (i) in subparagraph (A), by striking ``in subparagraph (B), a penalty may not be imposed under subsection (a) if" and all that follows through ``the failure to comply is corrected" and inserting ``in subparagraph (B) or subsection (a)(1)(C), a penalty may not be imposed under subsection (a) if the failure to comply is corrected"; and  (ii) in subparagraph (B), by striking ``(A)(ii)" and inserting ``(A)" each place it appears. (4) EFFECTIVE DATE.--The amendments made by this subsection shall apply to violations occurring after the date of the enactment of this title.		02/17/2009 and Thereafter

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(e) Enforcement Through State Attorneys General.-- (1) IN GENERAL.--Section 1176 of the Social Security Act (42 U.S.C. 1320d-5) is amended by adding at the end the following new subsection: ``(d) Enforcement by State Attorneys General.--  ``(1) CIVIL ACTION.--Except as provided in subsection (b), in any case in which the attorney general of a State has reason to believe that an interest of one or more of the residents of that State has been or is threatened or adversely affected by any person who violates a provision of this part, the attorney general of the State, as parens patriae, may bring a civil action on behalf of such residents of the State in a district court of the United States of appropriate jurisdiction-- ``(A) to enjoin further such violation by the defendant; or  ``(B) to obtain damages on behalf of such residents of the State, in an amount equal to the amount determined under paragraph (2). `` (2) STATUTORY DAMAGES.  ``(A) IN GENERAL.--For purposes of paragraph (1)(B), the amount determined under this paragraph is the amount calculated by multiplying the number of violations by up to $100. For purposes of the preceding sentence, in the case of a continuing violation, the number of violations shall be determined consistent		

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with the HIPAA privacy regulations (as defined in section 1180(b)(3)) for violations of subsection (a). ``(B) LIMITATION.--The total amount of damages imposed on the person for all violations of an identical requirement or prohibition during a calendar year may not exceed $25,000.  ``(C) REDUCTION OF DAMAGES.--In assessing damages under subparagraph (A), the court may consider the factors the Secretary may consider in determining the amount of a civil money penalty under subsection (a) under the HIPAA privacy regulations. ``(3) ATTORNEY FEES.--In the case of any successful action under paragraph (1), the court, in its discretion, may award the costs of the action and reasonable attorney fees to the State.  ``(4) NOTICE TO SECRETARY.--The State shall serve prior written notice of any action under paragraph (1) upon the Secretary and provide the Secretary with a copy of its complaint, except in any case in which such prior notice is not feasible, in which case the State shall serve such notice immediately upon instituting such action. The Secretary shall have the right-- ``(A) to intervene in the action;  ``(B) upon so intervening, to be heard on all matters arising therein; and ``(C) to file petitions for appeal.		

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``(5) CONSTRUCTION.--For purposes of bringing any civil action under paragraph (1), nothing in this section shall be construed to prevent an attorney general of a State from exercising the powers conferred on the attorney general by the laws of that State.  ``(6) VENUE; SERVICE OF PROCESS.-- ``(A) VENUE.--Any action brought under paragraph (1) may be brought in the district court of the United States that meets applicable requirements relating to venue under section 1391 of title 28, United States Code.  ``(B) SERVICE OF PROCESS.--In an action brought under paragraph (1), process may be served in any district in which the defendant-- ``(i) is an inhabitant; or  ``(ii) maintains a physical place of business. ``(7) LIMITATION ON STATE ACTION WHILE FEDERAL ACTION IS PENDING.--If the Secretary has instituted an action against a person under subsection (a) with respect to a specific violation of this part, no State attorney general may bring an action under this subsection against the person with respect to such violation during the pendency of that action. ``(8) APPLICATION OF CMP STATUTE OF LIMITATION.--A civil action may not be instituted with respect to a violation of this part unless an action to impose a civil money penalty may be instituted under		

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subsection (a) with respect to such violation consistent with the second sentence of section 1128A(c)(1).". (2) CONFORMING AMENDMENTS.--Subsection (b) of such section, as amended by subsection (d)(3), is amended-- (A) in paragraph (1), by striking ``A penalty may not be imposed under subsection (a)'' and inserting ``No penalty may be imposed under subsection (a) and no damages obtained under subsection (d)"; (B) in paragraph (2)(A)-- (i) after ``subsection (a)(1)(C),'', by striking ``a penalty may not be imposed under subsection (a)'' and inserting ``no penalty may be imposed under subsection (a) and no damages obtained under subsection (d)"; and  (ii) in clause (ii), by inserting ``or damages'' after ``the penalty";  (C) in paragraph (2)(B)(i), by striking ``The period'' and inserting ``With respect to the imposition of a penalty by the Secretary under subsection (a), the period"; and  (D) in paragraph (3), by inserting ``and any damages under subsection (d)'' after ``any penalty under subsection (a)". (3) EFFECTIVE DATE.--The amendments made by this subsection shall apply to violations occurring after the date of the enactment of this Act.		02/17/2009 and Thereafter

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(f) Allowing Continued Use of Corrective Action.--Such section is further amended by adding at the end the following new subsection: ``(e) Allowing Continued Use of Corrective Action.--Nothing in this section shall be construed as preventing the Office for Civil Rights of the Department of Health and Human Services from continuing, in its discretion, to use corrective action without a penalty in cases where the person did not know (and by exercising reasonable diligence would not have known) of the violation involved.".		
Section 13411 – Audits		
The Secretary shall provide for periodic audits to ensure that covered entities and business associates that are subject to the requirements of this subtitle and subparts C and E of part 164 of title 45, Code of Federal Regulations, as such provisions are in effect as of the date of enactment of this Act, comply with such requirements.	**Audits:** HIMSS supports this provision.	02/17/2010
Section 13424 – Effective Date		
Except as otherwise specifically provided, the provisions of Part I shall take effect on the date that is 12 months after the date of the enactment of this Title.	No comment necessary.	02/17/2010
Division B – Tax, Unemployment, Health, State Fiscal Relief, and other provisions **Title IV – HEALTH INFORMATION TECHNOLOGY** **"Medicare and Medicaid Health Information**		

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Technology; Miscellaneous Medicare Provisions **Subtitle A- Medicare Incentives**		
Section 4101: Incentives for Eligible Professionals		
Subject to the succeeding subparagraphs of this paragraph, with respect to covered professional services furnished by an eligible professional during a payment year (as defined in subparagraph (E)), if the eligible professional is a meaningful EHR user (as determined under paragraph (2)) for the EHR reporting period with respect to such year, in addition to the amount otherwise paid under this part, there also shall be paid to the eligible professional (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)), from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 an amount equal to 75 percent of the Secretary's estimate (based on claims submitted not later than 2 months after the end of the payment year) of the allowed charges under this part for all such covered professional services furnished by the eligible professional during such year. No incentive payments may be made under this subsection with respect to a year after 2016. (B) LIMITATIONS ON AMOUNTS OF INCENTIVE PAYMENTS.-- (i) IN GENERAL.--In no case shall the amount of the incentive payment provided under this paragraph for an eligible professional for a payment year exceed the applicable amount specified under this subparagraph with respect to such eligible professional and such year. (ii) AMOUNT.--Subject to clauses (iii) through (v), the	**Incentive Payments to Physicians through Medicare:** HIMSS supports the provisions to make available incentives to eligible Medicare providers that demonstrate a meaningful use of certified EHR technology. An eligible professional (i. a doctor of medicine or osteopathy, ii. a doctor of dental surgery or of dental medicine, iii. a doctor of podiatric medicine, iv. a doctor of optometry, and v. a chiropractor) will receive incentive payments for the first five years (2011 - 2015) for demonstrating meaningful use and performance during the reporting period for each payment year. If an eligible professional does not demonstrate meaningful use by 2015, his/her reimbursement payments under Medicare will begin to be reduced. To be eligible for the incentive payments, a professional should begin implementing a certified EHR by 2010 and demonstrate meaningful use beginning in 2011. The incentive amount available goes down for professionals who demonstrate meaningful use after 2013. No incentive payment will be made after 2016. HIMSS notes that HHS published rules in August 2006 providing an exception under the physician self-referral prohibition law (Stark). Under Stark an EHR would qualify for the donation if a certifying body has certified the EHR no more than 12 months before transfer to the physician office. HIMSS anticipates that the HHS Secretary will need to clarify the Stark impact on these incentives. A meaningful user is an eligible professional that : 1) Demonstrates to the satisfaction of the Secretary that during such period the professional is using certified EHR technology in a meaningful manner, which shall include the use of electronic prescribing as determined to be appropriate by the Secretary; 2) Demonstrates to the satisfaction of the Secretary that during such period such certified EHR technology is connected in a manner that provides, in accordance	Background date

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applicable amount specified in this subparagraph for an eligible professional is as follows: (I) For the first payment year for such professional, $15,000 (or, if the first payment year for such eligible professional is 2011 or 2012, $18,000). (II) For the second payment year for such professional, $12,000. (III) For the third payment year for such professional, $8,000. (IV) For the fourth payment year for such professional, $4,000. (V) For the fifth payment year for such professional, $2,000. (VI) For any succeeding payment year for such professional, $0. (iii) PHASE DOWN FOR ELIGIBLE PROFESSIONALS FIRST ADOPTING EHR AFTER 2013.--If the first payment year for an eligible professional is after 2013, then the amount specified in this subparagraph for a payment year for such professional is the same as the amount specified in clause (ii) for such payment year for an eligible professional whose first payment year is 2013. (iv) INCREASE FOR CERTAIN ELIGIBLE PROFESSIONALS.--In the case of an eligible professional who predominantly furnishes services under this part in an area that is designated by the Secretary (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area, the amount that would otherwise apply for a payment year for such professional under subclauses (I) through (V) of clause (ii) shall be increased by 10	with law and standards applicable to the exchange of information, for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination; 3) Submits information for such period, in a form and manner specified by the Secretary, on such clinical quality measures and such other measures as selected by the Secretary. Certified EHR technology means a qualified EHR that is certified to meeting standards pursuant to this Act and includes patient demographic and clinical health information, such as medical history and problem lists, and has the capacity to provide clinical decision support to support physician order entry, to capture and query information relevant to healthcare quality, and to exchange electronic health information with, and integrate such information from other sources. In an easy-to-understand format, the Secretary will publish online a listing of physician practices (along with contact information) that are meaningful users. A professional may satisfy the demonstration requirement means specified by the Secretary, which may include: (a) an attestation; (b) submission of claims with appropriate coding; (c) a survey response; (d) e-reporting of quality measures; or, (e) other means specified by the Secretary. The payment schedule for an eligible professional is as follows: **Payment Year** / **Incentive** First Payment Year — • $18,000 if the first payment year is 2011 or 2012 • $15,000 if the first payment year is 2013 • $12,000 if the first payment year is 2014 Second Payment Year — $12,000	Earliest date for incentives is January 1, 2011 Background date

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percent. In implementing the preceding sentence, the Secretary may, as determined appropriate, apply provisions of subsections (m) and (u) of section 1833 in a similar manner as such provisions apply under such subsection. (v) NO INCENTIVE PAYMENT IF FIRST ADOPTING AFTER 2014.--If the first payment year for an eligible professional is after 2014 then the applicable amount specified in this subparagraph for such professional for such year and any subsequent year shall be $0. (C) NON-APPLICATION TO HOSPITAL-BASED ELIGIBLE PROFESSIONALS.-- (i) IN GENERAL.--No incentive payment may be made under this paragraph in the case of a hospital-based eligible professional. (ii) HOSPITAL-BASED ELIGIBLE PROFESSIONAL.--For purposes of clause (i), the term `hospital-based eligible professional' means, with respect to covered professional services furnished by an eligible professional during the EHR reporting period for a payment year, an eligible professional, such as a pathologist, anesthesiologist, or emergency physician, who furnishes substantially all of such services in a hospital setting (whether inpatient or outpatient) and through the use of the facilities and equipment, including qualified electronic health records, of the hospital. The determination of whether an eligible professional is a hospital-based eligible professional shall be made on the basis of the site of service (as defined by the Secretary) and without regard to any employment or billing arrangement between the eligible professional and any other provider. (D) PAYMENT.--	<table><tr><td>Third Payment Year</td><td>$8,000</td></tr><tr><td>Fourth Payment Year</td><td>$4,000</td></tr><tr><td>Fifth Payment Year</td><td>$2,000</td></tr><tr><td colspan="2">*For eligible professionals in a health professional shortage area (HPSA), the incentive payment amounts will be increased by 10% *Payments are not available to hospital-based professionals (such as a pathologist, emergency room physician, or anesthesiologist).</td></tr></table> Please refer to the Appendices for a detailed payment schedule. Beginning in 2015, Medicare reimbursements are reduced on the following schedule for eligible professionals who cannot demonstrate meaningful use: 2015 = 99% 2016 = 98% 2017 and each subsequent year = 97% Through the legislation, qualified Medicare Advantage (MA) organizations can also receive incentive payments for the adoption and meaningful use of certified EHR technology by eligible professionals. Eligible professionals are defined under these provisions as follows: A: 1) Employed by a Medicare Advantage (MA) organization or are 2) Employed by, or a partner of, an entity that through a contract with the organization, furnishes at least 80 percent of the entity's Medicare patient care services to enrollees of such organization and furnishes at least 80 percent of the professional services of the eligible professional covered under this title to enrollees of the organization; and B: Furnishes, on average, at least 20 hours per week of patient care services. The legislation defines a qualifying MA organization as a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act). Incentives payments under this section can be made to a qualified MA organization as a substitute payment, through an amount as determined by the Secretary to the	Background date

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(i) FORM OF PAYMENT.--The payment under this paragraph may be in the form of a single consolidated payment or in the form of such periodic installments as the Secretary may specify. (ii) COORDINATION OF APPLICATION OF LIMITATION FOR PROFESSIONALS IN DIFFERENT PRACTICES.--In the case of an eligible professional furnishing covered professional services in more than one practice (as specified by the Secretary), the Secretary shall establish rules to coordinate the incentive payments, including the application of the limitation on amounts of such incentive payments under this paragraph, among such practices. (iii) COORDINATION WITH MEDICAID.--The Secretary shall seek, to the maximum extent practicable, to avoid duplicative requirements from Federal and State governments to demonstrate meaningful use of certified EHR technology under this title and title XIX. The Secretary may also adjust the reporting periods under such title and such subsections in order to carry out this clause. (E) PAYMENT YEAR DEFINED.-- (i) IN GENERAL.--For purposes of this subsection, the term `payment year' means a year beginning with 2011.  (ii) FIRST, SECOND, ETC. PAYMENT YEAR.--The term `first payment year' means, with respect to covered professional services furnished by an eligible professional, the first year for which an incentive payment is made for such services under this subsection. The terms `second payment year', `third payment year', `fourth payment year', and `fifth payment year' mean, with respect to covered professional services furnished by such eligible professional, each successive year immediately following the first payment year for such professional.	extent feasible and practical to be similar to the estimated amount in the aggregate that would be payable if payment for services furnished by such professionals was payable under Part B instead of this part. The legislation aims to address duplicative payments to MA organizations. An eligible professional that 1) is eligible for the maximum incentive payment under section 1848(o)(1)(A) for the same payment period, the payment incentive shall be made only under such section and not under this subsection; and that 2) is eligible for less than such maximum incentive payment for the same payment period, the payment incentive shall be made only under this subsection and not under section 1848(o)(1)(A). In addition, in the case that an eligible professional is eligible for an incentive payment under section 1848(o)(1)(A) but is not described in clause (i) of the section for the same payment period, the Secretary shall develop a process to ensure that duplicate payments are not made with respect to an eligible professional both under this subsection and under section 1848(o)(1)(A). The Secretary shall also collect data from Medicare Advantage organizations to ensure against such duplicate payments. A qualifying MA organization, in accordance with rules specified by the Secretary, shall specify a year (no earlier than 2011) that shall be treated as the first payment year for all professionals with respect to the organization. The legislation also refines, as outlined in the left-hand column, the payment adjustment to a MA organization as detailed in the section 1848(a)(7) under paragraph (1). In the case that a qualifying MA organization attests that not all eligible professionals of the organization are meaningful EHR users with respect to a year, the Secretary shall apply the payment adjustment under this paragraph based on the proportion of all such eligible professionals of the organization that are not meaningful EHR users for such year. A qualifying MA organization shall submit an attestation, in a form and manner specified by the Secretary which may include the submission of such attestation as	Background date

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(2) MEANINGFUL EHR USER.-- (A) IN GENERAL.--For purposes of paragraph (1), an eligible professional shall be treated as a meaningful EHR user for an EHR reporting period for a payment year (or, for purposes of subsection (a)(7), for an EHR reporting period under such subsection for a year) if each of the following requirements is met: (i) MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.--The eligible professional demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period the professional is using certified EHR technology in a meaningful manner, which shall include the use of electronic prescribing as determined to be appropriate by the Secretary. (ii) INFORMATION EXCHANGE.--The eligible professional demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period such certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination. (iii) REPORTING ON MEASURES USING EHR.--Subject to subparagraph (B)(ii) and using such certified EHR technology, the eligible professional submits information for such period, in a form and manner specified by the Secretary, on such clinical quality measures and such other measures as selected by the Secretary under subparagraph (B)(i). The Secretary may provide for the use of alternative means for meeting the requirements of clauses (i), (ii), and (iii) in the case of an eligible professional	part of submission of the initial bid under section 1854(a)(1)(A)(iv). In an easy-to-understand format, the Secretary will publish online a listing of the names, business addresses, and business phone numbers of each qualifying MA organization receiving an incentive payment under this subsection for eligible professionals of the organization and the eligible professionals of such organization for which such incentive payment is based. The Secretary shall conduct a study on the extent to which and manner in which payment incentives and adjustments could be made available to professionals, as defined in 1861 (r), who are not eligible for health IT incentive payments and receive payments for Medicare patient services nearly-exclusively through contractual arrangements with one or more MA organizations, or an intermediary organization or organizations with contracts with MA organizations. Such study shall assess approaches for measuring meaningful use of qualified EHR technology among such professionals and mechanisms for delivering incentives and adjustments to those professionals, including through incentive payments and adjustments through Medicare Advantage organizations or intermediary organizations. Please note that the legislation includes a clause that caps specified amounts that a provider can receive for professional services in a given year at 75%. Not later than 120 days after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the findings and the conclusions from the above study, together with recommendations for such legislation and administrative action as the Secretary determines appropriate. The provisions align with HIMSS' Legislative Principles and recommendations including in *"Enabling Healthcare Reform Using Information Technology"* concerning the need to leverage federally funded health programs to foster and support the use of health IT.	

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furnishing covered professional services in a group practice (as defined by the Secretary). The Secretary shall seek to improve the use of electronic health records and health care quality over time by requiring more stringent measures of meaningful use selected under this paragraph. (B) REPORTING ON MEASURES.-- (i) SELECTION.--The Secretary shall select measures for purposes of subparagraph (A)(iii) but only consistent with the following: (I) The Secretary shall provide preference to clinical quality measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a). (II) Prior to any measure being selected under this subparagraph, the Secretary shall publish in the Federal Register such measure and provide for a period of public comment on such measure. (ii) LIMITATION.--The Secretary may not require the electronic reporting of information on clinical quality measures under subparagraph (A)(iii) unless the Secretary has the capacity to accept the information electronically, which may be on a pilot basis. (iii) COORDINATION OF REPORTING OF INFORMATION.--In selecting such measures, and in establishing the form and manner for reporting measures under subparagraph (A)(iii), the Secretary shall seek to avoid redundant or duplicative reporting otherwise required, including reporting under subsection (k)(2)(C). (C) DEMONSTRATION OF MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY AND INFORMATION EXCHANGE.--	Please note that the CBO estimates the total cost of Medicare and Medicaid incentives for eligible professionals and hospitals that demonstrate a meaningful use of certified EHR technology to be $20.819. $20.819 is derived from the sum of the total costs of the incentives in fiscal year 2009 – fiscal year 2015 ($36.368 billion) and the total savings that are achieved in fiscal year 2016 – fiscal year 2019 through the incentives ($15.549 billion). **Limitation with Respect to EHR Incentive Payments:** The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorized an incentive program for eligible professionals utilizing e-prescribing. Eligible professionals seeking incentives under ARRA will no longer be eligible for MIPPA incentives.	

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(i) IN GENERAL.--A professional may satisfy the demonstration requirement of clauses (i) and (ii) of subparagraph (A) through means specified by the Secretary, which may include-- (I) an attestation; (II) the submission of claims with appropriate coding (such as a code indicating that a patient encounter was documented using certified EHR technology); (III) a survey response; (IV) reporting under subparagraph (A)(iii); and (V) other means specified by the Secretary. (ii) USE OF PART D DATA.--Notwithstanding sections 1860D-15(d)(2)(B) and 1860D-15(f)(2), the Secretary may use data regarding drug claims submitted for purposes of section 1860D-15 that are necessary for purposes of subparagraph (A). (3) APPLICATION.-- (A) PHYSICIAN REPORTING SYSTEM RULES.--Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this subsection in the same manner as they apply for purposes of such subsection. (B) COORDINATION WITH OTHER PAYMENTS.--The provisions of this subsection shall not be taken into account in applying the provisions of subsection (m) of this section and of section 1833(m) and any payment under such provisions shall not be taken into account in computing allowable charges under this subsection. (C) LIMITATIONS ON REVIEW.--There shall be no		

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administrative or judicial review under section 1869, section 1878, or otherwise, of-- (i) the methodology and standards for determining payment amounts under this subsection and payment adjustments under subsection (a)(7)(A), including the limitation under paragraph (1)(B) and coordination under clauses (ii) and (iii) of paragraph (1)(D); (ii) the methodology and standards for determining a meaningful EHR user under paragraph (2), including selection of measures under paragraph (2)(B), specification of the means of demonstrating meaningful EHR use under paragraph (2)(C), and the hardship exception under subsection (a)(7)(B); (iii) the methodology and standards for determining a hospital-based eligible professional under paragraph (1)(C); and (iv) the specification of reporting periods under paragraph (5) and the selection of the form of payment under paragraph (1)(D)(i). ``(D) POSTING ON WEBSITE.--The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names, business addresses, and business phone numbers of the eligible professionals who are meaningful EHR users and, as determined appropriate by the Secretary, of group practices receiving incentive payments under paragraph (1). (4) CERTIFIED EHR TECHNOLOGY DEFINED.--For purposes of this section, the term `certified EHR technology' means a qualified electronic health record (as defined in section 3000(13) of the Public Health Service Act) that is certified pursuant to section 3001(c)(5) of such Act as meeting standards adopted under section 3004 of such Act that are applicable to the		

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type of record involved (as determined by the Secretary, such as an ambulatory electronic health record for office-based physicians or an inpatient hospital electronic health record for hospitals). (5) DEFINITIONS.--For purposes of this subsection: (A) COVERED PROFESSIONAL SERVICES.--The term `covered professional services' has the meaning given such term in subsection (k)(3).  (B) EHR REPORTING PERIOD.--The term `EHR reporting period' means, with respect to a payment year, any period (or periods) as specified by the Secretary. (C) ELIGIBLE PROFESSIONAL.--The term `eligible professional' means a physician, as defined in section 1861(r).". (b) Incentive Payment Adjustment.--Section 1848(a) of the Social Security Act (42 U.S.C. 1395w-4(a)) is amended by adding at the end the following new paragraph: (7) INCENTIVES FOR MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.-- (A) ADJUSTMENT.-- (i) IN GENERAL.--Subject to subparagraphs (B) and (D), with respect to covered professional services furnished by an eligible professional during 2015 or any subsequent payment year, if the eligible professional is not a meaningful EHR user (as determined under subsection (o)(2)) for an EHR reporting period for the year, the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule		Background date

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amount that would otherwise apply to such services under this subsection (determined after application of paragraph (3) but without regard to this paragraph). (ii) APPLICABLE PERCENT.--Subject to clause (iii), for purposes of clause (i), the term `applicable percent' means-- (I) for 2015, 99 percent (or, in the case of an eligible professional who was subject to the application of the payment adjustment under section 1848(a)(5) for 2014, 98 percent); (II) for 2016, 98 percent; and (III) for 2017 and each subsequent year, 97 percent. (iii) AUTHORITY TO DECREASE APPLICABLE PERCENTAGE FOR 2018 AND SUBSEQUENT YEARS.--For 2018 and each subsequent year, if the Secretary finds that the proportion of eligible professionals who are meaningful EHR users (as determined under subsection (o)(2)) is less than 75 percent, the applicable percent shall be decreased by 1 percentage point from the applicable percent in the preceding year, but in no case shall the applicable percent be less than 95 percent. (B) SIGNIFICANT HARDSHIP EXCEPTION.--The Secretary may, on a case-by-case basis, exempt an eligible professional from the application of the payment adjustment under subparagraph (A) if the Secretary determines, subject to annual renewal, that compliance with the requirement for being a meaningful EHR user would result in a significant hardship, such as in the case of an eligible professional who practices in a rural area without sufficient Internet access. In no case may an eligible professional be granted an exemption under this subparagraph for more than 5 years.		Background date Background date Background date

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(C) APPLICATION OF PHYSICIAN REPORTING SYSTEM RULES.--Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in the same manner as they apply for purposes of such subsection. (D) NON-APPLICATION TO HOSPITAL-BASED ELIGIBLE PROFESSIONALS.--No payment adjustment may be made under subparagraph (A) in the case of hospital-based eligible professionals (as defined in subsection (o)(1)(C)(ii)). (E) DEFINITIONS.--For purposes of this paragraph: (i) COVERED PROFESSIONAL SERVICES.--The term `covered professional services' has the meaning given such term in subsection (k)(3).  (ii) EHR REPORTING PERIOD.--The term `EHR reporting period' means, with respect to a year, a period (or periods) specified by the Secretary. (iii) ELIGIBLE PROFESSIONAL.--The term `eligible professional' means a physician, as defined in section 1861(r).". (c) Application to Certain MA-Affiliated Eligible Professionals.--Section 1853 of the Social Security Act (42 U.S.C. 1395w-23) is amended by adding at the end the following new subsection: (l) Application of Eligible Professional Incentives for Certain MA Organizations for Adoption and Meaningful Use of Certified EHR Technology.-- (1) IN GENERAL.--Subject to paragraphs (3) and (4), in the case of a qualifying MA organization, the provisions of sections 1848(o) and 1848(a)(7) shall apply with respect to eligible professionals described in paragraph (2) of the organization who the organization		

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attests under paragraph (6) to be meaningful EHR users in a similar manner as they apply to eligible professionals under such sections. Incentive payments under paragraph (3) shall be made to and payment adjustments under paragraph (4) shall apply to such qualifying organizations. (2) ELIGIBLE PROFESSIONAL DESCRIBED.--With respect to a qualifying MA organization, an eligible professional described in this paragraph is an eligible professional (as defined for purposes of section 1848(o)) who-- (A)(i) is employed by the organization; or (ii)(I) is employed by, or is a partner of, an entity that through contract with the organization furnishes at least 80 percent of the entity's Medicare patient care services to enrollees of such organization; and (II) furnishes at least 80 percent of the professional services of the eligible professional covered under this title to enrollees of the organization; and (B) furnishes, on average, at least 20 hours per week of patient care services. ``(3) ELIGIBLE PROFESSIONAL INCENTIVE PAYMENTS.-- (A) IN GENERAL.--In applying section 1848(o) under paragraph (1), instead of the additional payment amount under section 1848(o)(1)(A) and subject to subparagraph (B), the Secretary may substitute an amount determined by the Secretary to the extent feasible and practical to be similar to the estimated amount in the aggregate that would be payable if payment for services furnished by such professionals was payable under part B instead of this part.		

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(B) AVOIDING DUPLICATION OF PAYMENTS.-- ``(i) IN GENERAL.--In the case of an eligible professional described in paragraph (2)-- (I) that is eligible for the maximum incentive payment under section 1848(o)(1)(A) for the same payment period, the payment incentive shall be made only under such section and not under this subsection; and (II) that is eligible for less than such maximum incentive payment for the same payment period, the payment incentive shall be made only under this subsection and not under section 1848(o)(1)(A). (ii) METHODS.--In the case of an eligible professional described in paragraph (2) who is eligible for an incentive payment under section 1848(o)(1)(A) but is not described in clause (i) for the same payment period, the Secretary shall develop a process-- (I) to ensure that duplicate payments are not made with respect to an eligible professional both under this subsection and under section 1848(o)(1)(A); and (II) to collect data from Medicare Advantage organizations to ensure against such duplicate payments. (C) FIXED SCHEDULE FOR APPLICATION OF LIMITATION ON INCENTIVE PAYMENTS FOR ALL ELIGIBLE PROFESSIONALS.--In applying section 1848(o)(1)(B)(ii) under subparagraph (A), in accordance with rules specified by the Secretary, a qualifying MA organization shall specify a year (not earlier than 2011) that shall be treated as the first payment year for all eligible professionals with respect to such organization. (4) PAYMENT ADJUSTMENT.--		Background date

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(A) IN GENERAL.--In applying section 1848(a)(7) under paragraph (1), instead of the payment adjustment being an applicable percent of the fee schedule amount for a year under such section, subject to subparagraph (D), the payment adjustment under paragraph (1) shall be equal to the percent specified in subparagraph (B) for such year of the payment amount otherwise provided under this section for such year. (B) SPECIFIED PERCENT.--The percent specified under this subparagraph for a year is 100 percent minus a number of percentage points equal to the product of-- (i) the number of percentage points by which the applicable percent (under section 1848(a)(7)(A)(ii)) for the year is less than 100 percent; and (ii) the Medicare physician expenditure proportion specified in subparagraph (C) for the year. (C) MEDICARE PHYSICIAN EXPENDITURE PROPORTION.--The Medicare physician expenditure proportion under this subparagraph for a year is the Secretary's estimate of the proportion, of the expenditures under parts A and B that are not attributable to this part, that are attributable to expenditures for physicians' services. (D) APPLICATION OF PAYMENT ADJUSTMENT.--In the case that a qualifying MA organization attests that not all eligible professionals of the organization are meaningful EHR users with respect to a year, the Secretary shall apply the payment adjustment under this paragraph based on the proportion of all such eligible professionals of the organization that are not meaningful EHR users for such year. (5) QUALIFYING MA ORGANIZATION DEFINED.--In this subsection and subsection (m), the term		

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`qualifying MA organization' means a Medicare Advantage organization that is organized as a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act). (6) MEANINGFUL EHR USER ATTESTATION.--For purposes of this subsection and subsection (m), a qualifying MA organization shall submit an attestation, in a form and manner specified by the Secretary which may include the submission of such attestation as part of submission of the initial bid under section 1854(a)(1)(A)(iv), identifying-- (A) whether each eligible professional described in paragraph (2), with respect to such organization is a meaningful EHR user (as defined in section 1848(o)(2)) for a year specified by the Secretary; and (B) whether each eligible hospital described in subsection (m)(1), with respect to such organization, is a meaningful EHR user (as defined in section 1886(n)(3)) for an applicable period specified by the Secretary. (7) POSTING ON WEBSITE.--The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names, business addresses, and business phone numbers of-- (A) each qualifying MA organization receiving an incentive payment under this subsection for eligible professionals of the organization; and (B) the eligible professionals of such organization for which such incentive payment is based. (8) LIMITATION ON REVIEW.--There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of--		

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(A) the methodology and standards for determining payment amounts and payment adjustments under this subsection, including avoiding duplication of payments under paragraph (3)(B) and the specification of rules for the fixed schedule for application of limitation on incentive payments for all eligible professionals under paragraph (3)(C); (B) the methodology and standards for determining eligible professionals under paragraph (2); and (C) the methodology and standards for determining a meaningful EHR user under section 1848(o)(2), including specification of the means of demonstrating meaningful EHR use under section 1848(o)(3)(C) and selection of measures under section 1848(o)(3)(B).". (d) Study and Report Relating to MA Organizations.-- (1) STUDY.--The Secretary of Health and Human Services shall conduct a study on the extent to which and manner in which payment incentives and adjustments (such as under sections 1848(o) and 1848(a)(7) of the Social Security Act) could be made available to professionals, as defined in 1861(r), who are not eligible for HIT incentive payments under section 1848(o) and receive payments for Medicare patient services nearly-exclusively through contractual arrangements with one or more Medicare Advantage organizations, or an intermediary organization or organizations with contracts with Medicare Advantage organizations. Such study shall assess approaches for measuring meaningful use of qualified EHR technology among such professionals and mechanisms for delivering incentives and adjustments to those professionals, including through incentive payments and adjustments through Medicare Advantage organizations or intermediary organizations.		NLT

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(2) REPORT.--Not later than 120 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the findings and the conclusions of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate. (e) Conforming Amendments.--Section 1853 of the Social Security Act (42 U.S.C. 1395w-23) is amended-- (1) in subsection (a)(1)(A), by striking ``and (i)'' and inserting ``(i), and (l)''; (2) in subsection (c)-- (A) in paragraph (1)(D)(i), by striking ``section 1886(h)'' and inserting ``sections 1848(o) and 1886(h)''; and (B) in paragraph (6)(A), by inserting after ``under part B,'' the following: ``excluding expenditures attributable to subsections (a)(7) and (o) of section 1848,''; and (3) in subsection (f), by inserting ``and for payments under subsection (l)'' after ``with the organization''. (f) Conforming Amendments to E-Prescribing. (1) Section 1848(a)(5)(A) of the Social Security Act (42 U.S.C. 1395w-4(a)(5)(A)) is amended-- (A) in clause (i), by striking ``or any subsequent year'' and inserting ``, 2013 or 2014''; and (B) in clause (ii), by striking ``and each subsequent year''.		06/17/2010

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(2) Section 1848(m)(2) of such Act (42 U.S.C. 1395w-4(m)(2)) is amended-- (A) in subparagraph (A), by striking ``For 2009'' and inserting ``Subject to subparagraph (D), for 2009''; and (B) by adding at the end the following new subparagraph: (D) **LIMITATION WITH RESPECT TO EHR INCENTIVE PAYMENTS.--**The provisions of this paragraph shall not apply to an eligible professional (or, in the case of a group practice under paragraph (3)(C), to the group practice) if, for the EHR reporting period the eligible professional (or group practice) receives an incentive payment under subsection (o)(1)(A) with respect to a certified EHR technology (as defined in subsection (o)(4)) that has the capability of electronic prescribing.''.		
Section 4102 – Incentives for Hospitals		

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SEC. 4102. INCENTIVES FOR HOSPITALS. (a) Incentive Payment.-- (1) IN GENERAL.--Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection: (n) Incentives for Adoption and Meaningful Use of Certified EHR Technology.-- (1) IN GENERAL.--Subject to the succeeding provisions of this subsection, with respect to inpatient hospital services furnished by an eligible hospital during a payment year (as defined in paragraph (2)(G)), if the eligible hospital is a meaningful EHR user (as determined under paragraph (3)) for the EHR reporting period with respect to such year, in addition to the amount otherwise paid under this section, there also shall be paid to the eligible hospital, from the Federal Hospital Insurance Trust Fund established under section 1817, an amount equal to the applicable amount specified in paragraph (2)(A) for the hospital for such payment year. (2) PAYMENT AMOUNT.-- (A) IN GENERAL.--Subject to the succeeding subparagraphs of this paragraph, the applicable amount specified in this subparagraph for an eligible hospital for a payment year is equal to the product of the following: (i) INITIAL AMOUNT.--The sum of--	**Incentive Payments to Hospitals through Medicare:** HIMSS supports the provisions to provide incentive payments through Medicare for hospitals (subsection (d) hospitals, which does not include i. rehabilitation hospitals, ii. hospitals where the patients are predominantly under age of eighteen, iii. hospitals having average inpatient stays of greater than twenty-five days, or iv. hospitals involved extensively in the treatment of or research on cancer) that demonstrate meaningful use of certified EHR systems. This provision establishes incentive payments for hospitals based on factors such as a hospital's discharge amount and Medicare share. Starting in fiscal year 2011, hospitals demonstrating meaningful use of a certified EHR system become eligible for the incentives laid out at left. Incentives are lessened for hospitals which don't become eligible until after fiscal year 2013. And, starting in fiscal year 2015, hospitals will begin to experience reductions in Medicare payments if they cannot demonstrate meaningful use. A hospital should begin to implement or upgrade to a certified EHR technology now. To receive the maximum in incentive payments, hospitals must be able to demonstrate the meaningful use of certified EHR technology beginning in fiscal year 2011. HIMSS notes that HHS published rules in August 2006 providing an exception under the physician self-referral prohibition law (Stark). Under Stark an EHR would qualify for the donation if a certifying body has certified the EHR no more than 12 months before transfer to the physician office. HIMSS anticipates that the HHS Secretary will need to clarify the Stark impact on these incentives. An eligible hospital shall be treated as a meaningful EHR user for an EHR reporting period for a payment year if each of the following requirements are met: 1)The eligible hospital demonstrates to the satisfaction of the Secretary that during such period the hospital is using certified EHR technology in a meaningful manner; 2) The eligible hospital demonstrates to the satisfaction of the Secretary that during such period such certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, for	

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(I) the base amount specified in subparagraph (B); plus (II) the discharge related amount specified in subparagraph (C) for a 12-month period selected by the Secretary with respect to such payment year. (ii) MEDICARE SHARE.--The Medicare share as specified in subparagraph (D) for the eligible hospital for a period selected by the Secretary with respect to such payment year. (iii) TRANSITION FACTOR.--The transition factor specified in subparagraph (E) for the eligible hospital for the payment year. (B) BASE AMOUNT.--The base amount specified in this subparagraph is $2,000,000. (C) DISCHARGE RELATED AMOUNT.--The discharge related amount specified in this subparagraph for a 12-month period selected by the Secretary shall be determined as the sum of the amount, estimated based upon total discharges for the eligible hospital (regardless of any source of payment) for the period, for each discharge up to the 23,000th discharge as follows: (i) For the first through 1,149th discharge, $0. (ii) For the 1,150th through the 23,000th discharge, $200. (iii) For any discharge greater than the 23,000th, $0.	the electronic exchange of health information to improve the quality of health care, such as promoting care coordination; 3) The eligible hospital submits information for such period, in a form and manner specified by the Secretary, on such clinical quality measures and such other measures as selected by the Secretary. Certified EHR technology means a qualified EHR that is certified to meeting standards pursuant to this Act and includes patient demographic and clinical health information, such as medical history and problem lists, and has the capacity to provide clinical decision support to support physician order entry, to capture and query information relevant to healthcare quality, and to exchange electronic health information with, and integrate such information from other sources. Further, the Secretary of HHS is directed to improve the use of EHRs and healthcare quality over time by requiring increasingly stringent measures of meaningful use. The quality measures to be reported will be selected by the Secretary for this purpose, or those that have been endorsed by an entity under contract with the Secretary. The Secretary will publish online a listing of hospitals that are meaningful users – along with other data of the Secretary's choosing – in an easy-to-understand format. The Secretary may choose from any of the following means for a hospital to satisfy the requirement of demonstrating meaningful use of EHR technology: (a) an attestation; (b) submission of claims with appropriate coding; (c) a survey response; (d) e-reporting of quality measures; or, (e) other means specified by the Secretary. The base amount available is $2M for all eligible hospitals. In addition, eligible hospitals can receive additional incentive payments based upon the quantity of annual discharges, a Medicare share, and a transition factor. Specific schedules for discharges can be found at left under (C). The Medicare share can be found at left under (D) and the transition factor formula is under (E). Regarding the incentive Market Basket Adjustment - beginning in FY15, those hospitals who do not demonstrate meaningful use of EHR technology, ¾ of the applicable percentage increase that the hospital would otherwise be entitled to will	

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(D) MEDICARE SHARE.--The Medicare share specified under this subparagraph for an eligible hospital for a period selected by the Secretary for a payment year is equal to the fraction--(i) the numerator of which is the sum (for such period and with respect to the eligible hospital) of—(I) the estimated number of inpatient-bed-days (as established by the Secretary) which are attributable to individuals with respect to whom payment may be made under part A; and (II) the estimated number of inpatient-bed-days (as so established) which are attributable to individuals who are enrolled with a Medicare Advantage organization under part C; and (ii) the denominator of which is the product of-(I) the estimated total number of inpatient-bed-days with respect to the eligible hospital during such period; and(II) the estimated total amount of the eligible hospital's charges during such period, not including any charges that are attributable to charity care (as such term is used for purposes of hospital cost reporting under this title), divided by the estimated total amount of the hospital's charges during such period. Insofar as the Secretary determines that data are not available on charity care necessary to calculate the portion of the formula specified in clause (ii)(II), the Secretary shall use data on uncompensated care and may adjust such data so as to be an appropriate proxy for charity care including a downward adjustment to eliminate bad debt data from uncompensated care data. In the absence of the data necessary, with respect to a hospital, for the Secretary to compute the amount described in clause (ii)(II), the amount under such clause shall be deemed to be 1. In the absence of data, with respect to a hospital, necessary to compute the	be reduced by 33 1/3 % for FY15; by 66 2/3 % for FY16; and, 100% for FY17.Please refer to the Appendices for additional information concerning incentive payments for hospitals. To calculate incentive payments for non-critical access hospitals, please access the Incentive Payment Worksheet for Non-Critical Access Hospitals. The payment formula for a critical access hospital, that is an eligible hospital in accordance with the Act, which is a meaningful user of certified EHR technology, is the same as the formula that is calculated for eligible hospitals, with the exception of how the Medicare Share is calculated. After the Medicare Share is derived, 20 percentage points must be added to that amount. In addition, the Medicare Share cannot be larger than 100%. To calculate incentive payments for critical access hospitals, please access the Incentives Payment Worksheet for Critical Access Hospitals. The legislation includes a separate formula for a critical access hospital who does not demonstrate meaningful use of EHR technology by FY15. Specifically, ¾ of the applicable percentage increase that the critical hospital would otherwise be entitled to will be reduced by 100.66 % for FY15; 100.33 % for FY16; and 100% by FY17 and each subsequent year. Through the legislation, qualified MA organizations can also receive incentive payments for the adoption and meaningful use of certified EHR technology by eligible hospitals. An eligible hospital per these provisions is a hospital 1) as defined as eligible in section 4102, 2) is under a common corporate governance with a MA organization, and 3) serves individuals enrolled under an MA plan offered by the MA organization. Incentives are to be paid to qualified MA organizations based on a substitute amount, determined by the Secretary, for payments made under Medicare Part A. The legislation, as detailed in the left hand column, specifies how the Secretary	

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amount described in clause (i)(II), the amount under such clause shall be deemed to be 0. (E) TRANSITION FACTOR SPECIFIED.-- (i) IN GENERAL.--Subject to clause (ii), the transition factor specified in this subparagraph for an eligible hospital for a payment year is as follows: (I) For the first payment year for such hospital, 1. (II) For the second payment year for such hospital, 3/4 . (III) For the third payment year for such hospital, 1/2. (IV) For the fourth payment year for such hospital, 1/4. (V) For any succeeding payment year for such hospital, 0. (ii) PHASE DOWN FOR ELIGIBLE HOSPITALS FIRST ADOPTING EHR AFTER 2013.--If the first payment year for an eligible hospital is after 2013, then the transition factor specified in this subparagraph for a payment year for such hospital is the same as the amount specified in clause (i) for such payment year for an eligible hospital for which the first payment year is 2013. If the first payment year for an eligible hospital is after 2015 then the transition factor specified in this subparagraph for such hospital and for such year and any subsequent year shall be 0.	should determine the incentive amount. In an effort to avoid duplicative payment under this section for a payment year, in the case that a hospital is an eligible hospital and for which at least one-third of their discharges (or bed days) of Medicare patients for the year are covered under Part A, payment for the payment year shall be made per the payment structure foreligible hospitals in this section, not eligible hospitals that are affiliated with a MA organization. For those hospitals that are not included in the definition of eligible hospitals and do not have at least one-third of their discharges (or bed days) of Medicare patients for the year covered under Part A, the Secretary shall develop a process to ensure that duplicate payments are not made with respect to eligible hospitals and to collect data from MA organizations to ensure against such duplicate payments. In the case that one or more eligible hospitals that are under common corporate governance with a MA organization and serve individuals enrolled under a plan offered by the MA organization are not meaningful EHR users with respect to a period, the payment amount payable to the MA organization shall be the following percent: The percent specified under this subparagraph for a year is 100 percent minus a number of percentage points equal to the product of: 1) the number of the percentage point reduction effected under section 1886(b)(3)(B)ix)(I) of the Social Security Act for the period and 2) the Medicare hospital expenditure proportion. The Medicare hospital expenditure proportion for a year is the Secretary's estimate of the proportion, of the expenditures under Parts A and B that are not attributable to this part, that are attributable to expenditures for inpatient hospital services. In the case that a qualifying MA organization attests that not all eligible hospitals are meaningful EHR users with respect to an applicable period, the Secretary shall apply the payment adjustment under this paragraph based on a methodology specified by the Secretary, taking into account the proportion of such eligible hospitals, or discharges from such hospitals, that are not meaningful EHR users for	Background date

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(F) FORM OF PAYMENT.--The payment under this subsection for a payment year may be in the form of a single consolidated payment or in the form of such periodic installments as the Secretary may specify. (G) PAYMENT YEAR DEFINED.-- (i) IN GENERAL.--For purposes of this subsection, the term `payment year' means a fiscal year beginning with fiscal year 2011.  (ii) FIRST, SECOND, ETC. PAYMENT YEAR.--The term `first payment year' means, with respect to inpatient hospital services furnished by an eligible hospital, the first fiscal year for which an incentive payment is made for such services under this subsection. The terms `second payment year', `third payment year', and `fourth payment year' mean, with respect to an eligible hospital, each successive year immediately following the first payment year for that hospital. (3) MEANINGFUL EHR USER.-- (A) IN GENERAL.--For purposes of paragraph (1), an eligible hospital shall be treated as a meaningful EHR user for an EHR reporting period for a payment year (or, for purposes of subsection (b)(3)(B)(ix), for an EHR reporting period under such subsection for a fiscal year) if each of the following requirements are met: (i) MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.--The eligible hospital demonstrates to the satisfaction of the Secretary, in accordance with	such period. In an easily understandable format, the Secretary shall publish on a website, a list of the names, business addresses, and business phone numbers of each qualifying MA organization receiving an incentive payment under this subsection and a list of the names of the eligible hospitals for which such incentive payment is based.The provisions align with HIMSS' Legislative Principles and recommendations including in *"Enabling Healthcare Reform Using Information Technology"* concerning the need to leverage federally funded health programs to foster and support the use of health IT. Please note that CBO estimates the total cost of Medicare and Medicaid incentives for eligible professionals and hospitals that demonstrate a meaningful use of certified EHR technology to be $20.819. $20.819 is derived from the sum of the total costs of the incentives in fiscal year 2009 – fiscal year 2015 ($36.368 billion) and the total savings that are achieved in fiscal year 2016 – fiscal year 2019 through the incentives ($15.549 billion). **Open Source Health IT Systems:** HIMSS supports the provision to require the Secretary, along with federal counterparts, to conduct a study on the availability, costs, and benefits for providers concerning open source health IT. HIMSS agrees the Secretary ought to make recommendations for such legislation and administrative action, as appropriate. Open source technology provides valuable options for the healthcare industry and health information exchange. HIMSS recommends the Secretary to assess the costs of implementing open source and explore how best to utilize its benefits.	Earliest date of implementation for hospitals to receive incentives is October 1, 2010

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subparagraph (C)(i), that during such period the hospital is using certified EHR technology in a meaningful manner. (ii) INFORMATION EXCHANGE.--The eligible hospital demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period such certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination. (iii) REPORTING ON MEASURES USING EHR.--Subject to subparagraph (B)(ii) and using such certified EHR technology, the eligible hospital submits information for such period, in a form and manner specified by the Secretary, on such clinical quality measures and such other measures as selected by the Secretary under subparagraph (B)(i). The Secretary shall seek to improve the use of electronic health records and health care quality over time by requiring more stringent measures of meaningful use selected under this paragraph. (B) REPORTING ON MEASURES. (i) SELECTION.--The Secretary shall select measures for purposes of subparagraph (A)(iii) but only consistent with the following: (I) The Secretary shall provide preference to clinical		

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quality measures that have been selected for purposes of applying subsection (b)(3)(B)(viii) or that have been endorsed by the entity with a contract with the Secretary under section 1890(a). (II) Prior to any measure (other than a clinical quality measure that has been selected for purposes of applying subsection (b)(3)(B)(viii)) being selected under this subparagraph, the Secretary shall publish in the *Federal Register* such measure and provide for a period of public comment on such measure. (ii) LIMITATIONS.--The Secretary may not require the electronic reporting of information on clinical quality measures under subparagraph (A)(iii) unless the Secretary has the capacity to accept the information electronically, which may be on a pilot basis. (iii) COORDINATION OF REPORTING OF INFORMATION.--In selecting such measures, and in establishing the form and manner for reporting measures under subparagraph (A)(iii), the Secretary shall seek to avoid redundant or duplicative reporting with reporting otherwise required, including reporting under subsection (b)(3)(B)(viii). (C) DEMONSTRATION OF MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY AND INFORMATION EXCHANGE.-- (i) IN GENERAL.--An eligible hospital may satisfy the demonstration requirement of clauses (i) and (ii) of subparagraph (A) through means specified by the Secretary, which may include--		

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(I) an attestation; (II) the submission of claims with appropriate coding (such as a code indicating that inpatient care was documented using certified EHR technology); (III) a survey response; (IV) reporting under subparagraph (A)(iii); and (V) other means specified by the Secretary. (ii) USE OF PART D DATA.--Notwithstanding sections 1860D-15(d)(2)(B) and 1860D-15(f)(2), the Secretary may use data regarding drug claims submitted for purposes of section 1860D-15 that are necessary for purposes of subparagraph (A). (4) APPLICATION.-- (A) LIMITATIONS ON REVIEW.--There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of-- (i) the methodology and standards for determining payment amounts under this subsection and payment adjustments under subsection (b)(3)(B)(ix), including selection of periods under paragraph (2) for determining, and making estimates or using proxies of, discharges under paragraph (2)(C) and inpatient-bed-days, hospital charges, charity charges, and Medicare share under paragraph (2)(D);		

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(ii) the methodology and standards for determining a meaningful EHR user under paragraph (3), including selection of measures under paragraph (3)(B), specification of the means of demonstrating meaningful EHR use under paragraph (3)(C), and the hardship exception under subsection (b)(3)(B)(ix)(II); and (iii) the specification of EHR reporting periods under paragraph (6)(B) and the selection of the form of payment under paragraph (2)(F). (B) POSTING ON WEBSITE.--The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names of the eligible hospitals that are meaningful EHR users under this subsection or subsection (b)(3)(B)(ix) (and a list of the names of critical access hospitals to which paragraph (3) or (4) of section 1814(l) applies), and other relevant data as determined appropriate by the Secretary. The Secretary shall ensure that an eligible hospital (or critical access hospital) has the opportunity to review the other relevant data that are to be made public with respect to the hospital (or critical access hospital) prior to such data being made public. (5) CERTIFIED EHR TECHNOLOGY DEFINED.--The term `certified EHR technology' has the meaning given such term in section 1848(o)(4).  (6) DEFINITIONS.--For purposes of this subsection:  (A) EHR REPORTING PERIOD.--The term `EHR reporting period' means, with respect to a payment year,		

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any period (or periods) as specified by the Secretary. (B) ELIGIBLE HOSPITAL.--The term `eligible hospital' means a subsection (d) hospital.". (2) CRITICAL ACCESS HOSPITALS.--Section 1814(l) of the Social Security Act (42 U.S.C. 1395f(l)) is amended-- (A) in paragraph (1), by striking ``paragraph (2)'' and inserting ``the subsequent paragraphs of this subsection''; and (B) by adding at the end the following new paragraph: (3)(A) The following rules shall apply in determining payment and reasonable costs under paragraph (1) for costs described in subparagraph (C) for a critical access hospital that would be a meaningful EHR user (as would be determined under paragraph (3) of section 1886(n)) for an EHR reporting period for a cost reporting period beginning during a payment year if such critical access hospital was treated as an eligible hospital under such section: (i) The Secretary shall compute reasonable costs by expensing such costs in a single payment year and not depreciating such costs over a period of years (and shall include as costs with respect to cost reporting periods beginning during a payment year costs from previous cost reporting periods to the extent they have not been fully depreciated as of the period involved). (ii) There shall be substituted for the Medicare share that would otherwise be applied under paragraph (1) a		

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percent (not to exceed 100 percent) equal to the sum of-- (I) the Medicare share (as would be specified under paragraph (2)(D) of section 1886(n)) for such critical access hospital if such critical access hospital was treated as an eligible hospital under such section; and (II) 20 percentage points. (B) The payment under this paragraph with respect to a critical access hospital shall be paid through a prompt interim payment (subject to reconciliation) after submission and review of such information (as specified by the Secretary) necessary to make such payment, including information necessary to apply this paragraph. In no case may payment under this paragraph be made with respect to a cost reporting period beginning during a payment year after 2015 and in no case may a critical access hospital receive payment under this paragraph with respect to more than 4 consecutive payment years. (C) The costs described in this subparagraph are costs for the purchase of certified EHR technology to which purchase depreciation (excluding interest) would apply if payment was made under paragraph (1) and not under this paragraph. (D) For purposes of this paragraph, paragraph (4), and paragraph (5), the terms `certified EHR technology', `eligible hospital', `EHR reporting period', and `payment year' have the meanings given such terms in sections 1886(n).". (b) Incentive Market Basket Adjustment.--		Background date

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(1) IN GENERAL.--Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)) is amended-- (A) in clause (viii)(I), by inserting ``(or, beginning with fiscal year 2015, by one-quarter)'' after ``2.0 percentage points''; and (B) by adding at the end the following new clause: (ix)(I) For purposes of clause (i) for fiscal year 2015 and each subsequent fiscal year, in the case of an eligible hospital (as defined in subsection (n)(6)(A)) that is not a meaningful EHR user (as defined in subsection (n)(3)) for an EHR reporting period for such fiscal year, three-quarters of the applicable percentage increase otherwise applicable under clause (i) for such fiscal year shall be reduced by 33 1/3 percent for fiscal year 2015, 66 2/3 percent for fiscal year 2016, and 100 percent for fiscal year 2017 and each subsequent fiscal year. Such reduction shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause (i) for a subsequent fiscal year. (II) The Secretary may, on a case-by-case basis, exempt a subsection (d) hospital from the application of subclause (I) with respect to a fiscal year if the Secretary determines, subject to annual renewal, that requiring such hospital to be a meaningful EHR user during such fiscal year would result in a significant hardship, such as in the case of a hospital in a rural area without sufficient Internet access. In no case may a		Background date

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hospital be granted an exemption under this subclause for more than 5 years. (III) For fiscal year 2015 and each subsequent fiscal year, a State in which hospitals are paid for services under section 1814(b)(3) shall adjust the payments to each subsection (d) hospital in the State that is not a meaningful EHR user (as defined in subsection (n)(3)) in a manner that is designed to result in an aggregate reduction in payments to hospitals in the State that is equivalent to the aggregate reduction that would have occurred if payments had been reduced to each subsection (d) hospital in the State in a manner comparable to the reduction under the previous provisions of this clause. The State shall report to the Secretary the methodology it will use to make the payment adjustment under the previous sentence. (IV) For purposes of this clause, the term `EHR reporting period' means, with respect to a fiscal year, any period (or periods) as specified by the Secretary.". (2) CRITICAL ACCESS HOSPITALS.--Section 1814(l) of the Social Security Act (42 U.S.C. 1395f(l)), as amended by subsection (a)(2), is further amended by adding at the end the following new paragraphs: (4)(A) Subject to subparagraph (C), for cost reporting periods beginning in fiscal year 2015 or a subsequent fiscal year, in the case of a critical access hospital that is not a meaningful EHR user (as would be determined under paragraph (3) of section 1886(n) if such critical access hospital was treated as an eligible hospital under such section) for an EHR reporting period with respect		Background date Background date

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to such fiscal year, paragraph (1) shall be applied by substituting the applicable percent under subparagraph (B) for the percent described in such paragraph (1). (B) The percent described in this subparagraph is-- (i) for fiscal year 2015, 100.66 percent; (ii) for fiscal year 2016, 100.33 percent; and (iii) for fiscal year 2017 and each subsequent fiscal year, 100 percent. (C) The provisions of subclause (II) of section 1886(b)(3)(B)(ix) shall apply with respect to subparagraph (A) for a critical access hospital with respect to a cost reporting period beginning in a fiscal year in the same manner as such subclause applies with respect to subclause (I) of such section for a subsection (d) hospital with respect to such fiscal year. (5) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of-- (A) the methodology and standards for determining the amount of payment and reasonable cost under paragraph (3) and payment adjustments under paragraph (4), including selection of periods under section 1886(n)(2) for determining, and making estimates or using proxies of, inpatient-bed-days, hospital charges, charity charges, and Medicare share under subparagraph (D) of section 1886(n)(2); (B) the methodology and standards for determining a		Background date Background date

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meaningful EHR user under section 1886(n)(3) as would apply if the hospital was treated as an eligible hospital under section 1886(n), and the hardship exception under paragraph (4)(C); (C) the specification of EHR reporting periods under section 1886(n)(6)(B) as applied under paragraphs (3) and (4); and (D) the identification of costs for purposes of paragraph (3)(C).". (c) Application to Certain MA-Affiliated Eligible Hospitals.--Section 1853 of the Social Security Act (42 U.S.C. 1395w-23), as amended by section 4101(c), is further amended by adding at the end the following new subsection: (m) Application of Eligible Hospital Incentives for Certain MA Organizations for Adoption and Meaningful Use of Certified EHR Technology.-- (1) APPLICATION.--Subject to paragraphs (3) and (4), in the case of a qualifying MA organization, the provisions of sections 1886(n) and 1886(b)(3)(B)(ix) shall apply with respect to eligible hospitals described in paragraph (2) of the organization which the organization attests under subsection (l)(6) to be meaningful EHR users in a similar manner as they apply to eligible hospitals under such sections. Incentive payments under paragraph (3) shall be made to and payment adjustments under paragraph (4) shall apply to such qualifying organizations.		

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(2) ELIGIBLE HOSPITAL DESCRIBED.--With respect to a qualifying MA organization, an eligible hospital described in this paragraph is an eligible hospital (as defined in section 1886(n)(6)(A)) that is under common corporate governance with such organization and serves individuals enrolled under an MA plan offered by such organization. (3) ELIGIBLE HOSPITAL INCENTIVE PAYMENTS.-- (A) IN GENERAL.--In applying section 1886(n)(2) under paragraph (1), instead of the additional payment amount under section 1886(n)(2), there shall be substituted an amount determined by the Secretary to be similar to the estimated amount in the aggregate that would be payable if payment for services furnished by such hospitals was payable under part A instead of this part. In implementing the previous sentence, the Secretary-- (i) shall, insofar as data to determine the discharge related amount under section 1886(n)(2)(C) for an eligible hospital are not available to the Secretary, use such alternative data and methodology to estimate such discharge related amount as the Secretary determines appropriate; and (ii) shall, insofar as data to determine the Medicare share described in section 1886(n)(2)(D) for an eligible hospital are not available to the Secretary, use such alternative data and methodology to estimate such share, which data and methodology may include use of the inpatient-bed-days (or discharges) with respect to an		

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eligible hospital during the appropriate period which are attributable to both individuals for whom payment may be made under part A or individuals enrolled in an MA plan under a Medicare Advantage organization under this part as a proportion of the estimated total number of patient-bed-days (or discharges) with respect to such hospital during such period. (B) AVOIDING DUPLICATION OF PAYMENTS.-- (i) IN GENERAL.--In the case of a hospital that for a payment year is an eligible hospital described in paragraph (2) and for which at least one-third of their discharges (or bed-days) of Medicare patients for the year are covered under part A, payment for the payment year shall be made only under section 1886(n) and not under this subsection. (ii) METHODS.--In the case of a hospital that is an eligible hospital described in paragraph (2) and also is eligible for an incentive payment under section 1886(n) but is not described in clause (i) for the same payment period, the Secretary shall develop a process-- (I) to ensure that duplicate payments are not made with respect to an eligible hospital both under this subsection and under section 1886(n); and (II) to collect data from Medicare Advantage organizations to ensure against such duplicate payments. (4) PAYMENT ADJUSTMENT.-- (A) Subject to paragraph (3), in the case of a qualifying		

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MA organization (as defined in section 1853(l)(5)), if, according to the attestation of the organization submitted under subsection (l)(6) for an applicable period, one or more eligible hospitals (as defined in section 1886(n)(6)(A)) that are under common corporate governance with such organization and that serve individuals enrolled under a plan offered by such organization are not meaningful EHR users (as defined in section 1886(n)(3)) with respect to a period, the payment amount payable under this section for such organization for such period shall be the percent specified in subparagraph (B) for such period of the payment amount otherwise provided under this section for such period. (B) SPECIFIED PERCENT.--The percent specified under this subparagraph for a year is 100 percent minus a number of percentage points equal to the product of-- (i) the number of the percentage point reduction effected under section 1886(b)(3)(B)(ix)(I) for the period; and (ii) the Medicare hospital expenditure proportion specified in subparagraph (C) for the year. (C) MEDICARE HOSPITAL EXPENDITURE PROPORTION.--The Medicare hospital expenditure proportion under this subparagraph for a year is the Secretary's estimate of the proportion, of the expenditures under parts A and B that are not attributable to this part, that are attributable to expenditures for inpatient hospital services.		

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(D) APPLICATION OF PAYMENT ADJUSTMENT.--In the case that a qualifying MA organization attests that not all eligible hospitals are meaningful EHR users with respect to an applicable period, the Secretary shall apply the payment adjustment under this paragraph based on a methodology specified by the Secretary, taking into account the proportion of such eligible hospitals, or discharges from such hospitals, that are not meaningful EHR users for such period. (5) POSTING ON WEBSITE.--The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format-- (A) a list of the names, business addresses, and business phone numbers of each qualifying MA organization receiving an incentive payment under this subsection for eligible hospitals described in paragraph (2); and (B) a list of the names of the eligible hospitals for which such incentive payment is based. (6) LIMITATIONS ON REVIEW.--There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of-- (A) the methodology and standards for determining payment amounts and payment adjustments under this subsection, including avoiding duplication of payments under paragraph (3)(B); (B) the methodology and standards for determining eligible hospitals under paragraph (2); and		

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(C) the methodology and standards for determining a meaningful EHR user under section 1886(n)(3), including specification of the means of demonstrating meaningful EHR use under subparagraph (C) of such section and selection of measures under subparagraph (B) of such section.". (d) Conforming Amendments.-- (1) Section 1814(b) of the Social Security Act (42 U.S.C. 1395f(b)) is amended-- (A) in paragraph (3), in the matter preceding subparagraph (A), by inserting ``, subject to section 1886(d)(3)(B)(ix)(III)," after ``then"; and (B) by adding at the end the following: ``For purposes of applying paragraph (3), there shall be taken into account incentive payments, and payment adjustments under subsection (b)(3)(B)(ix) or (n) of section 1886.".  (2) Section 1851(i)(1) of the Social Security Act (42 U.S.C. 1395w-21(i)(1)) is amended by striking ``and 1886(h)(3)(D)" and inserting ``1886(h)(3)(D), and 1853(m)".  (3) Section 1853 of the Social Security Act (42 U.S.C. 1395w-23), as amended by section 4101(d), is amended--  (A) in subsection (c)--  (i) in paragraph (1)(D)(i), by striking ``1848(o)" and inserting ``, 1848(o), and 1886(n)"; and		

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(ii) in paragraph (6)(A), by inserting ``and subsections (b)(3)(B)(ix) and (n) of section 1886'' after ``section 1848''; and (B) in subsection (f), by inserting ``and subsection (m)'' after ``under subsection (l)''. SEC. 4103. TREATMENT OF PAYMENTS AND SAVINGS; IMPLEMENTATION FUNDING. (a) Premium Hold Harmless.-- (1) IN GENERAL.--Section 1839(a)(1) of the Social Security Act (42 U.S.C. 1395r(a)(1)) is amended by adding at the end the following: ``In applying this paragraph there shall not be taken into account additional payments under section 1848(o) and section 1853(l)(3) and the Government contribution under section 1844(a)(3).''. (2) PAYMENT.--Section 1844(a) of such Act (42 U.S.C. 1395w(a)) is amended-- (A) in paragraph (2), by striking the period at the end and inserting ``; plus''; and (B) by adding at the end the following new paragraph: (3) a Government contribution equal to the amount of payment incentives payable under sections 1848(o) and 1853(l)(3).''		

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(b) Medicare Improvement Fund.--Section 1898 of the Social Security Act (42 U.S.C. 1395iii), as added by section 7002(a) of the Supplemental Appropriations Act, 2008 (Public Law 110-252) and as amended by section 188(a)(2) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275; 122 Stat. 2589) and by section 6 of the QI Program Supplemental Funding Act of 2008, is amended-- (1) in subsection (a)-- (A) by inserting ``Medicare'' before ``fee-for-service''; and (B) by inserting before the period at the end the following: ``including, but not limited to, an increase in the conversion factor under section 1848(d) to address, in whole or in part, any projected shortfall in the conversion factor for 2014 relative to the conversion factor for 2008 and adjustments to payments for items and services furnished by providers of services and suppliers under such original Medicare fee-for-service program''; and (2) in subsection (b)-- (A) in paragraph (1), by striking ``during fiscal year 2014,'' and all that follows and inserting the following: ``during-- (A) fiscal year 2014, $22,290,000,000; and (B) fiscal year 2020 and each subsequent fiscal year, the Secretary's estimate, as of July 1 of the fiscal year, of		Background date Background date

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the aggregate reduction in expenditures under this title during the preceding fiscal year directly resulting from the reduction in payment amounts under sections 1848(a)(7), 1853(l)(4), 1853(m)(4), and 1886(b)(3)(B)(ix)."; and (B) by adding at the end the following new paragraph: (4) NO EFFECT ON PAYMENTS IN SUBSEQUENT YEARS.--In the case that expenditures from the Fund are applied to, or otherwise affect, a payment rate for an item or service under this title for a year, the payment rate for such item or service shall be computed for a subsequent year as if such application or effect had never occurred.". (c) Implementation Funding.--In addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services for the Center for Medicare & Medicaid Services Program Management Account, $100,000,000 for each of fiscal years 2009 through 2015 and $45,000,000 for fiscal year 2016, which shall be available for purposes of carrying out the provisions of (and amendments made by) this subtitle. Amounts appropriated under this subsection for a fiscal year shall be available until expended. SEC. 4104. STUDIES AND REPORTS ON HEALTH INFORMATION TECHNOLOGY. (a) Study and Report on Application of EHR		Background date NLT 06/30/2010

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Payment Incentives for Providers Not Receiving Other Incentive Payments.-- (1) STUDY.-- (A) IN GENERAL.--The Secretary of Health and Human Services shall conduct a study to determine the extent to which and manner in which payment incentives (such as under title XVIII or XIX of the Social Security Act) and other funding for purposes of implementing and using certified EHR technology (as defined in section 1848(o)(4) of the Social Security Act, as added by section 4101(a)) should be made available to health care providers who are receiving minimal or no payment incentives or other funding under this Act, under title XIII of division A, under title XVIII or XIX of such Act, or otherwise, for such purposes. (B) DETAILS OF STUDY.--Such study shall include an examination of-- (i) the adoption rates of certified EHR technology by such health care providers; (ii) the clinical utility of such technology by such health care providers; (iii) whether the services furnished by such health care providers are appropriate for or would benefit from the use of such technology; (iv) the extent to which such health care providers work in settings that might otherwise receive an incentive payment or other funding under this Act,		

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under title XIII of division A, under title XVIII or XIX of the Social Security Act, or otherwise; (v) the potential costs and the potential benefits of making payment incentives and other funding available to such health care providers; and (vi) any other issues the Secretary deems to be appropriate. (2) REPORT.--Not later than June 30, 2010, the Secretary shall submit to Congress a report on the findings and conclusions of the study conducted under paragraph (1). (b) Study and Report on Availability of Open Source Health Information Technology Systems.-- (1) STUDY.-- (A) IN GENERAL.--The Secretary of Health and Human Services shall, in consultation with the Under Secretary for Health of the Veterans Health Administration, the Director of the Indian Health Service, the Secretary of Defense, the Director of the Agency for Healthcare Research and Quality, the Administrator of the Health Resources and Services Administration, and the Chairman of the Federal Communications Commission, conduct a study on-- (i) the current availability of open source health information technology systems to Federal safety net providers (including small, rural providers);		NLT 10/01/2010

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(ii) the total cost of ownership of such systems in comparison to the cost of proprietary commercial products available; (iii) the ability of such systems to respond to the needs of, and be applied to, various populations (including children and disabled individuals); and (iv) the capacity of such systems to facilitate interoperability. (B) CONSIDERATIONS.--In conducting the study under subparagraph (A), the Secretary of Health and Human Services shall take into account the circumstances of smaller health care providers, health care providers located in rural or other medically underserved areas, and safety net providers that deliver a significant level of health care to uninsured individuals, Medicaid beneficiaries, SCHIP beneficiaries, and other vulnerable individuals. (2) REPORT.--Not later than October 1, 2010, the Secretary of Health and Human Services shall submit to Congress a report on the findings and the conclusions of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.		
Subtitle B – Medicaid Funding **Section 4201 – Medicaid provider HIT adoption and operation payments; implementation funding**		
(a) In General.--Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended--	**Incentives to Providers through Medicaid:** HIMSS supports the provisions to make available incentives to Medicaid providers that demonstrate a meaningful use	

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(1) in subsection (a)(3)-- (A) by striking ``and'' at the end of subparagraph (D);  (B) by striking ``plus'' at the end of subparagraph (E) and inserting ``and''; and (C) by adding at the end the following new subparagraph: (F)(i) 100 percent of so much of the sums expended during such quarter as are attributable to payments to Medicaid providers described in subsection (t)(1) to encourage the adoption and use of certified EHR technology; and (ii) 90 percent of so much of the sums expended during such quarter as are attributable to payments for reasonable administrative expenses related to the administration of payments described in clause (i) if the State meets the condition described in subsection (t)(9); plus''; and (2) by inserting after subsection (s) the following new subsection: (t)(1) For purposes of subsection (a)(3)(F), the payments described in this paragraph to encourage the adoption and use of certified EHR technology are payments made by the State in accordance with this subsection-- (A) to Medicaid providers described in paragraph	of certified EHR technologies. This section provides funding through State Medicaid programs to Medicaid providers (professionals and hospitals as described in the Act) that demonstrate a meaningful use of certified EHR technologies. The legislation does not specify a year in which funding begins. Based upon written Senate sources, we believe it is likely that funding will start in 2011. Under this section Medicaid providers eligible for funding are defined as: • Non-hospital-based providers with at least 30 percent of patient volume attributable to individuals who are receiving medical assistance under this title; • Non-hospital-based pediatricians who have at least 20 percent of the professional's patient volume attributable to individuals who are receiving medical assistance under this title; • Those who practice predominately in a Federally qualified health center or rural health clinic and has at least 30 percent of the professional's patient volume attributable to needy individuals; • A children's hospital or an acute care hospital that is not a children's hospital – and that have at least 10 percent of the hospital's patient volume attributable to individuals who are receiving medical assistance under this title may receive not in excess of the maximum amount permitted for the provider involved. Professionals in the first three bullets above include physicians, dentists, certified nurse midwives, and physician assistants practicing in rural health clinics or Federally-qualified health centers led by a physician assistant. The definition of "meaningful use" must be established through a means that is approved by the State and acceptable to the Secretary. As a further step, the definition must be in alignment with the one used for Medicare (see HIMSS analysis of "Incentive Payments to Physicians through Medicare" above). Certified EHR technology means a qualified EHR that is certified to meeting standards pursuant to this Act. The Secretary has until Dec. 31, 2009 to adopt an initial set of certification criteria for ambulatory EHRs and inpatient hospital EHRs. The Secretary shall select a certifying body that is already in existence. Based upon	

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(2)(A) not in excess of 85 percent of net average allowable costs (as defined in paragraph (3)(E)) for certified EHR technology (and support services including maintenance and training that is for, or is necessary for the adoption and operation of, such technology) with respect to such providers; and (B) to Medicaid providers described in paragraph (2)(B) not in excess of the maximum amount permitted under paragraph (5) for the provider involved. (2) In this subsection and subsection (a)(3)(F), the term `Medicaid provider' means-- (A) an eligible professional (as defined in paragraph (3)(B))-- (i) who is not hospital-based and has at least 30 percent of the professional's patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this title; (ii) who is not described in clause (i), who is a pediatrician, who is not hospital-based, and who has at least 20 percent of the professional's patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this title; and (iii) who practices predominantly in a Federally qualified health center or rural health clinic and has at least 30 percent of the professional's patient volume (as estimated in accordance with a methodology established	the definition found elsewhere in the legislation, "qualified" EHRs are those that includes patient demographic and clinical health information, such as medical history and problem lists, and has the capacity to provide clinical decision support to support physician order entry, to capture and query information relevant to healthcare quality, and to exchange electronic health information with, and integrate such information from other sources. This section does not include language referring to reductions in Medicaid payments if a provider does not adopt certified EHR technology. Under this section of the Act, eligible providers can receive not in excess of 85 percent of net average allowable costs for certified EHR technology (and support services including maintenance and training that is for, or is necessary for the adoption and operation of, such technology). To determine the average costs, the Secretary will study the costs associated with adoption and use of certified EHR technology among Medicaid providers. First Payment Year for eligible professionals – Up to $25,000 (or a lesser amount based upon studies being conducted by the Secretary) for the: • Costs for the purchase and initial implementation or upgrade of the certified EHR technology; or, • Demonstrating that the eligible professional is engaged in efforts to adopt, implement, or upgrade certified EHR technology; or, • Demonstrating that an investment in the adoption and use of certified EHR technology was made prior to beginning of the funding period. Second Payment Year for eligible professionals – Up to $10,000 to pay for the cost of the operation, maintenance, and use of the certified EHR technology. The legislative language does not include the term "upgrade". HIMSS will watch this situation closely. Payment caveat pertaining to eligible providers: in the case of non-hospital-based pediatricians for whom at least 20 percent of their patient volume comes from Medicaid, the funding amount available is 2/3 of the first payment year ($16,500); and, 2/3 of the second payment year ($6,600).	

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by the Secretary) attributable to needy individuals (as defined in paragraph (3)(F)); and (B)(i) a children's hospital, or (ii) an acute-care hospital that is not described in clause (i) and that has at least 10 percent of the hospital's patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this title. An eligible professional shall not qualify as a Medicaid provider under this subsection unless any right to payment under sections 1848(o) and 1853(l) with respect to the eligible professional has been waived in a manner specified by the Secretary. For purposes of calculating patient volume under subparagraph (A)(iii), insofar as it is related to uncompensated care, the Secretary may require the adjustment of such uncompensated care data so that it would be an appropriate proxy for charity care, including a downward adjustment to eliminate bad debt data from uncompensated care. In applying subparagraphs (A) and (B)(ii), the methodology established by the Secretary for patient volume shall include individuals enrolled in a Medicaid managed care plan (under section 1903(m) or section 1932). (3) In this subsection and subsection (a)(3)(F): (A) The term `certified EHR technology' means a qualified electronic health record (as defined in 3000(13) of the Public Health Service Act) that is	Regarding funding for eligible hospitals, the base amount available is the same as the amount outlined in the hospital Medicare incentive section – $2M. In addition, eligible hospitals can receive additional incentive payments based upon the quantity of annual discharges, a Medicare share, and a transition factor. The specific calculation can be found in Section 4201 (2)(A)(i). However, as per this section of the legislation, two important differences must be noted in order to correctly calculate the amount of funding available. First, Congress has stipulated that the Medicare share is 1. Second, in computing payment amounts for payment years after the first year, the Secretary is directed to assume discharge rates will increase at the average annual rate of the most recent three years for which the hospital has data discharge information available. The Secretary, in consultation with the State, will determine the overall hospital EHR amount for each eligible hospital using the updated language in Section 1903 of the Social Security Act. The change in the Social Security Act impacts the formulas used to determine the amount the Secretary provides each State for its Medicaid services plan. Specifically, the change is to replace the word “plus” with the word “and” at the end of (a)(3)(E)(ii). The Secretary is required to submit periodic reports to Congress describing the extent of certified EHR technology among Medicaid providers and any improvement in health outcomes, clinical quality, or efficiency resulting from such adoption. The legislation instructs the Secretary to ensure the coordination of incentive payments to providers through Medicare and Medicaid. Such coordination shall include, to the extent practicable, a data matching process between State Medicaid agencies and the Centers for Medicare & Medicaid Services using national provider identifiers. To carry-out these activities, the Secretary may require the submission of such data relating to payments to such Medicaid providers as the Secretary may specify. The provisions align with HIMSS’ Legislative Principles and recommendations including in *“Enabling Healthcare Reform Using Information Technology”*	

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certified pursuant to section 3001(c)(5) of such Act as meeting standards adopted under section 3004 of such Act that are applicable to the type of record involved (as determined by the Secretary, such as an ambulatory electronic health record for office-based physicians or an inpatient hospital electronic health record for hospitals). (B) The term `eligible professional' means a-- (i) physician; (ii) dentist; (iii) certified nurse mid-wife; (iv) nurse practitioner; and (v) physician assistant insofar as the assistant is practicing in a rural health clinic that is led by a physician assistant or is practicing in a Federally qualified health center that is so led. (C) The term `average allowable costs' means, with respect to certified EHR technology of Medicaid providers described in paragraph (2)(A) for-- (i) the first year of payment with respect to such a provider, the average costs for the purchase and initial implementation or upgrade of such technology (and support services including training that is for, or is necessary for the adoption and initial operation of, such technology) for such providers, as determined by the Secretary based upon studies conducted under	concerning the need to leverage federally funded health programs to foster and support the use of health IT. Please note that CBO estimates the total cost of Medicare and Medicaid incentives for eligible professionals and hospitals that demonstrate a meaningful use of certified EHR technology to be $20.819. $20.819 is derived from the sum of the total costs of the incentives in fiscal year 2009 – fiscal year 2015 ($36.368 billion) and the total savings that are achieved in fiscal year 2016 – fiscal year 2019 through the incentives ($15.549 billion). .	

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paragraph (4)(C); and (ii) a subsequent year of payment with respect to such a provider, the average costs not described in clause (i) relating to the operation, maintenance, and use of such technology for such providers, as determined by the Secretary based upon studies conducted under paragraph (4)(C). (D) The term `hospital-based' means, with respect to an eligible professional, a professional (such as a pathologist, anesthesiologist, or emergency physician) who furnishes substantially all of the individual's professional services in a hospital setting (whether inpatient or outpatient) and through the use of the facilities and equipment, including qualified electronic health records, of the hospital. The determination of whether an eligible professional is a hospital-based eligible professional shall be made on the basis of the site of service (as defined by the Secretary) and without regard to any employment or billing arrangement between the eligible professional and any other provider. (E) The term `net average allowable costs' means, with respect to a Medicaid provider described in paragraph (2)(A), average allowable costs reduced by any payment that is made to such Medicaid provider from any other source (other than under this subsection or by a State or local government) that is directly attributable to payment for certified EHR technology or support services described in subparagraph (C). (F) The term `needy individual' means, with respect to		

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a Medicaid provider, an individual-- (i) who is receiving assistance under this title; (ii) who is receiving assistance under title XXI; (iii) who is furnished uncompensated care by the provider; or (iv) for whom charges are reduced by the provider on a sliding scale basis based on an individual's ability to pay. (4)(A) With respect to a Medicaid provider described in paragraph (2)(A), subject to subparagraph (B), in no case shall-- (i) the net average allowable costs under this subsection for the first year of payment (which may not be later than 2016), which is intended to cover the costs described in paragraph (3)(C)(i), exceed $25,000 (or such lesser amount as the Secretary determines based on studies conducted under subparagraph (C)); (ii) the net average allowable costs under this subsection for a subsequent year of payment, which is intended to cover costs described in paragraph (3)(C)(ii), exceed $10,000; and (iii) payments be made for costs described in clause (ii) after 2021 or over a period of longer than 5 years. (B) In the case of Medicaid provider described in paragraph (2)(A)(ii), the dollar amounts specified in		

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subparagraph (A) shall be 2/3 of the dollar amounts otherwise specified. (C) For the purposes of determining average allowable costs under this subsection, the Secretary shall study the average costs to Medicaid providers described in paragraph (2)(A) of purchase and initial implementation and upgrade of certified EHR technology described in paragraph (3)(C)(i) and the average costs to such providers of operations, maintenance, and use of such technology described in paragraph (3)(C)(ii). In determining such costs for such providers, the Secretary may utilize studies of such amounts submitted by States. (5)(A) In no case shall the payments described in paragraph (1)(B) with respect to a Medicaid provider described in paragraph (2)(B) exceed-- (i) in the aggregate the product of-- (I) the overall hospital EHR amount for the provider computed under subparagraph (B); and (II) the Medicaid share for such provider computed under subparagraph (C); (ii) in any year 50 percent of the product described in clause (i); and (iii) in any 2-year period 90 percent of such product. (B) For purposes of this paragraph, the overall hospital EHR amount, with respect to a Medicaid provider, is		

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the sum of the applicable amounts specified in section 1886(n)(2)(A) for such provider for the first 4 payment years (as estimated by the Secretary) determined as if the Medicare share specified in clause (ii) of such section were 1. The Secretary shall establish, in consultation with the State, the overall hospital EHR amount for each such Medicaid provider eligible for payments under paragraph (1)(B). For purposes of this subparagraph in computing the amounts under section 1886(n)(2)(C) for payment years after the first payment year, the Secretary shall assume that in subsequent payment years discharges increase at the average annual rate of growth of the most recent 3 years for which discharge data are available per year. (C) The Medicaid share computed under this subparagraph, for a Medicaid provider for a period specified by the Secretary, shall be calculated in the same manner as the Medicare share under section 1886(n)(2)(D) for such a hospital and period, except that there shall be substituted for the numerator under clause (i) of such section the amount that is equal to the number of inpatient-bed-days (as established by the Secretary) which are attributable to individuals who are receiving medical assistance under this title and who are not described in section 1886(n)(2)(D)(i). In computing inpatient-bed-days under the previous sentence, the Secretary shall take into account inpatient-bed-days attributable to inpatient-bed-days that are paid for individuals enrolled in a Medicaid managed care plan (under section 1903(m) or section 1932). (D) In no case may the payments described in paragraph (1)(B) with respect to a Medicaid provider described in		

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paragraph (2)(B) be paid-- (i) for any year beginning after 2016 unless the provider has been provided payment under paragraph (1)(B) for the previous year; and (ii) over a period of more than 6 years of payment. (6) Payments described in paragraph (1) are not in accordance with this subsection unless the following requirements are met: (A)(i) The State provides assurances satisfactory to the Secretary that amounts received under subsection (a)(3)(F) with respect to payments to a Medicaid provider are paid, subject to clause (ii), directly to such provider (or to an employer or facility to which such provider has assigned payments) without any deduction or rebate. (ii) Amounts described in clause (i) may also be paid to an entity promoting the adoption of certified EHR technology, as designated by the State, if participation in such a payment arrangement is voluntary for the eligible professional involved and if such entity does not retain more than 5 percent of such payments for costs not related to certified EHR technology (and support services including maintenance and training) that is for, or is necessary for the operation of, such technology. (B) A Medicaid provider described in paragraph (2)(A) is responsible for payment of the remaining 15 percent of the net average allowable cost.		Background date

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(C)(i) Subject to clause (ii), with respect to payments to a Medicaid provider-- (I) for the first year of payment to the Medicaid provider under this subsection, the Medicaid provider demonstrates that it is engaged in efforts to adopt, implement, or upgrade certified EHR technology; and (II) for a year of payment, other than the first year of payment to the Medicaid provider under this subsection, the Medicaid provider demonstrates meaningful use of certified EHR technology through a means that is approved by the State and acceptable to the Secretary, and that may be based upon the methodologies applied under section 1848(o) or 1886(n). (ii) In the case of a Medicaid provider who has completed adopting, implementing, or upgrading such technology prior to the first year of payment to the Medicaid provider under this subsection, clause (i)(I) shall not apply and clause (i)(II) shall apply to each year of payment to the Medicaid provider under this subsection, including the first year of payment. (D) To the extent specified by the Secretary, the certified EHR technology is compatible with State or Federal administrative management systems. For purposes of subparagraph (B), a Medicaid provider described in paragraph (2)(A) may accept payments for the costs described in such subparagraph from a State or local government. For purposes of subparagraph (C), in establishing the means described		

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in such subparagraph, which may include clinical quality reporting to the State, the State shall ensure that populations with unique needs, such as children, are appropriately addressed. (7) With respect to Medicaid providers described in paragraph (2)(A), the Secretary shall ensure coordination of payment with respect to such providers under sections 1848(o) and 1853(l) and under this subsection to assure no duplication of funding. Such coordination shall include, to the extent practicable, a data matching process between State Medicaid agencies and the Centers for Medicare & Medicaid Services using national provider identifiers. For such purposes, the Secretary may require the submission of such data relating to payments to such Medicaid providers as the Secretary may specify. (8) In carrying out paragraph (6)(C), the State and Secretary shall seek, to the maximum extent practicable, to avoid duplicative requirements from Federal and State governments to demonstrate meaningful use of certified EHR technology under this title and title XVIII. In doing so, the Secretary may deem satisfaction of requirements for such meaningful use for a payment year under title XVIII to be sufficient to qualify as meaningful use under this subsection. The Secretary may also specify the reporting periods under this subsection in order to carry out this paragraph. (9) In order to be provided Federal financial participation under subsection (a)(3)(F)(ii), a State must demonstrate to the satisfaction of the Secretary, that the State--		

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(A) is using the funds provided for the purposes of administering payments under this subsection, including tracking of meaningful use by Medicaid providers; (B) is conducting adequate oversight of the program under this subsection, including routine tracking of meaningful use attestations and reporting mechanisms; and (C) is pursuing initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information under this title, subject to applicable laws and regulations governing such exchange. (10) The Secretary shall periodically submit reports to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate on status, progress, and oversight of payments described in paragraph (1), including steps taken to carry out paragraph (7). Such reports shall also describe the extent of adoption of certified EHR technology among Medicaid providers resulting from the provisions of this subsection and any improvements in health outcomes, clinical quality, or efficiency resulting from such adoption.". (b) Implementation Funding.--In addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services for the Centers for Medicare & Medicaid Services Program Management Account, $40,000,000 for each of fiscal		Background date

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years 2009 through 2015 and $20,000,000 for fiscal year 2016, which shall be available for purposes of carrying out the provisions of (and the amendments made by) this section. Amounts appropriated under this subsection for a fiscal year shall be available until expended.		
Title X- MILITARY CONSTRCUTION AND VETERANS AFFAIRS AND RELATED AGENCIES **Department of Veterans Affairs**		
Veterans Health Administration		
For an additional amount for `Information Technology Systems', $50,000,000, to remain available until September 30, 2010, for the Veterans Benefits Administration: *Provided*, That not later than 30 days after the enactment of this Act, the Secretary of Veterans Affairs shall submit to the Committees on Appropriations of both Houses of Congress an expenditure plan for funds provided under this heading.	**Veterans Benefits Administration and Paperless Claims Processing:** HIMSS supports the provision that authorizes and appropriates funding for the Veterans Benefits Administration (VBA) for the development of paperless claims processing. HIMSS encourages the Department to coordinate with the Social Security Administration to determine any synergies between VBA activities and SSA Disability Claims work with clinicians and current EHR vendors/users.	Upon Enactment NLT 03/17/2009