



Section-by-Section Summary of the Health Care Provisions
of the “American Recovery and Reinvestment Act”

February 17, 2009

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Premium Assistance for COBRA Benefits	<p><i>Premium Assistance under COBRA</i> – Allows eligible individuals to receive a premium subsidy in the amount of 65% of a COBRA qualified plan.</p> <p>Allows an assistance eligible individual, within 90 days of notice of the plan enrollment option, to elect coverage under a plan that is different than coverage in which the individual was enrolled at the time of the qualifying event, if the following conditions are met:</p> <ul style="list-style-type: none"> • the employer allows such individuals to enroll in different coverage; • the premium for different coverage does not exceed the premium for coverage in which the individual was enrolled at the time the qualified event occurred; • the different coverage is also offered to active employees; • the different coverage is not: 1) coverage that provides only dental, vision, counseling, or referral services (or a combination of such services); 2) a flexible spending arrangement (as defined in section 106(c)(2) of the IRC); and 3) coverage that provides for services or treatments furnished in an on-site medical facility maintained by the employer and that consists primarily of first-aid services, prevention and wellness care, or similar care (or a combination of such care). <p>Terminates the premium assistance on or after the earlier of:</p> <ol style="list-style-type: none"> 1. the first date when an individual is eligible for coverage under any other group health plan (other than coverage consisting of only dental, vision, counseling, or referral services); coverage under a flexible spending arrangement (as defined in section 106(c)(2) of the IRC); coverage of treatment that is furnished in an on-site medical facility maintained by the employer that consists primarily of first-aid services, prevention and wellness care, or similar care; or is eligible for Medicare; or 2. the earliest of the date 9 months after eligibility for COBRA; the date following the expiration of the maximum period of continuation coverage required under applicable COBRA continuation coverage provision; or the date following the expiration

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	<p style="text-align: center;">of the period of continuation coverage as allowed under the extended election period (see below).</p> <p>Requires an individual to not be treated as eligible for coverage under a group plan (for purposes of number 1. above) before the first date on which such individual could be covered under the plan.</p> <p><i>Notice Requirement for Individuals</i> – Requires the individual to notify the group health plan issuing the COBRA continuation coverage if the individual becomes eligible for other coverage (outlined under number 1 above). Requires the Secretary of Labor to specify the time and manner of the notification.</p> <p>The term “assistance eligible individual” means a qualified beneficiary if: 1) at any time between September 1, 2008 and December 31, 2009, the individual is eligible for COBRA continuation coverage; 2) such individual elects coverage; and 3) the qualifying event for COBRA continuation coverage consists of the involuntary termination of the covered employee’s employment and occurred during such period.</p> <p><i>Extended COBRA Continuation Coverage Election Period</i> – Grants individuals who became eligible for COBRA continuation coverage between September 1, 2008 and the enactment of this Act, but did not elect coverage, an extension of the election period lasting 60 days commencing on the date when the individual received notification from the group health plan outlining the individual’s eligibility. Requires COBRA continuation coverage, if elected by such an individual, to commence with the first period of coverage beginning on or after the date of enactment of this Act and limits the period of COBRA continuation coverage to the coverage that would have been required under the applicable COBRA continuation coverage provision if the coverage had been elected as required under such provisions. For an individual who elects coverage under the extended election period, the gap in coverage will be disregarded for purposes of determining the 63-day periods (re: preexisting conditions) referred to under ERISA, the Internal Revenue Code (IRC), and the Public Health Service Act (PHSA).</p> <p><i>Expedited Review of Denials of Premium Assistance</i> – Grants individuals, who request treatment as an assistance eligible individual, access to expedited review if such request for premium assistance is denied. Requires the Secretaries of Labor, Health and Human Services (HHS), and Treasury to provide for such review, in a form and manner as provided by the Secretary. Requires the Secretary to make a determination within 15 business days after receipt of an individual’s application for review. Requires each Secretary’s determination upon the de novo review of the denial to be the final determination. Requires a reviewing court to grant deference to such Secretary’s determination. Requires certain provisions of this section to be treated as provisions of title I of ERISA for purposes of part 5 of subtitle B (regarding administration and enforcement of that title).</p> <p><i>Disregard of Subsidies for Purposes of Federal and State Programs</i> – Prohibits the premium reduction from being considered income or resources in determining eligibility for, or the amount of assistance or benefits provided under, any other public benefit provided under federal law or the law of any state or state political subdivision.</p> <p><i>Employer Notification Requirements</i> – Requires the COBRA continuation coverage issued by the group health plan to include an additional notification of the availability of premium assistance as allowed under this Act, including the option to enroll in different</p>

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	<p>coverage (as described above). Requires the Secretaries of Labor, HHS, and Treasury to coordinate with group health plans to provide rules requiring the provision of such notice. Allows the notification requirement to be met by amendment of existing notice forms or by inclusion of a separate document with the notice otherwise required. Requires such notice to contain additional forms and information that allows the individual to apply for premium assistance; include the description of the obligation upon the individual to notify the group plan of eligibility of other coverage; and state the individual’s right to a reduced premium. Requires the group health plan to issue within 60 days after enactment of this Act a notice regarding an individual’s eligibility for premium assistance, for those individuals who elected COBRA continuation coverage between September 1, 2008 and the enactment of this Act, and those who are eligible for COBRA continuation coverage under the extended election period. Requires the Secretaries of Labor, HHS, and Treasury to prescribe models for the additional notification required under this subsection within 30 days after the enactment of this Act.</p> <p>Requires the Secretary of the Treasury to provide rules, procedures, regulations, and other guidelines appropriate to prevent fraud and abuse under this section, except that the Secretary of Labor and the Secretary of HHS may prescribe such regulations or other guidance as may be necessary or appropriate to carry out certain provisions. Requires the Secretaries of Labor, HHS, and Treasury to provide outreach consisting of public education and enrollment assistance related to the premium assistance provided under this subsection.</p> <p>Defines “COBRA continuation coverage” as the continuation coverage provided pursuant to provisions under ERISA, the Public Health Service Act, the Internal Revenue Code, or section 8905a of title 5 (referred to government employees) or under a State program that provides comparable continuation coverage. Such term does not include coverage under a health flexible spending arrangement under a cafeteria plan.</p> <p><i>Report to Congress</i> – Requires the Secretary of the Treasury to provide an interim report to Congress that includes the number of people receiving premium assistance and the amount of expenditures incurred in connection with such premium assistance. Requires the Secretary to submit a final report, after the last period of COBRA continuation coverage for which premium assistance is provided, that includes the number of individuals provided premium assistance; the average dollar amount (monthly and annually) of premium reductions provided to such individuals; and the total amount of expenditures incurred (with administrative expenditures noted separately) in connection with such premium assistance.</p> <p>[Sec. 3001]</p>
COBRA Premium Assistance - Treatment of Payroll Taxes	<p><i>Treatment of Payroll Taxes Related to COBRA Premium Assistance</i> – Outlines those entities that are eligible for reimbursement under certain conditions, including a group health plan that is a multiemployer, an employer that maintains the group health plan, or the insurer. Provides that the premium assistance that is transmitted to eligible individuals will be treated as a credit against the requirement to make deposits of payroll taxes. Defines “payroll taxes” as amounts deducted and withheld relating to wage withholding and FICA employee and employer taxes. Dictates the manner in which an entity must treat the credit (as it is applied upon receipt of the qualified beneficiary’s premium payment) and the requirement of the entity to report the involuntary termination of employment; the amount of payroll taxes offset under this section; the estimated offsets of such taxes for the subsequent reporting period in connection with such reimbursements; and the Tax Identification Numbers (TINs) of all covered employees, the amount of subsidy reimbursed with respect to each covered employee and qualified beneficiaries, and a designation with respect to each covered employee as to whether the subsidy reimbursement is for coverage of one individual or two or more individuals.</p>

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	<p>Requires the Secretary to issue regulations or guidance as may be necessary to carry out this section, including the requirement to report information or other means of verifying the correct amounts of premium reimbursement and the application of this section to group health plans that are multiemployer plans.</p> <p>For an individual who pays the full COBRA premium for any month beginning on the first day of the first month of enactment of this Act, requires the employer to make a reimbursement to such individual for the amount of such premium paid in excess of 35% or provide credit to the individual in a manner that reduces 1 or more of the individual’s premium payments. Such employers will be reimbursed by the federal government.</p> <p>[Sec. 3001]</p>
Penalty for Failure to Notify Health Plan of Cessation of Eligibility for COBRA Premium Assistance	Allows the Secretary of Labor to fine individuals 110% of the premium assistance for those individuals who fail to notify the group health plan issuing the COBRA continuation coverage that the individual became eligible for other coverage. Prohibits a penalty if such failure is due to reasonable cause and not willful neglect. Amendment applies to failures occurring after the enactment of this Act. [Sec. 3001]
Coordinating with Health Coverage Tax Credit	Prohibits an assistance eligible individual who receives premium reduction for COBRA continuation coverage from being treated as an eligible individual, a certified individual, or a qualifying family member for coverage under the Health Coverage Tax Credit. Amendment applies to taxable years ending after the enactment of this Act. [Sec. 3001]
COBRA Premium Assistance – Exclusion from Gross Income	Excludes premium reduction for COBRA continuation coverage from inclusion as gross income. [Sec. 3001]
Elimination of Premium Subsidy for High-income Individuals	Recaptures the subsidy (in the form of a tax increase) if an individual receives premium subsidy under this section in a taxable year and the individual’s modified adjusted gross income for the corresponding taxable year exceeds \$125,000 (\$250,000 in the case of a joint return). Requires individuals whose modified adjusted gross income for the taxable year is \$145,000 (\$290,000 in the case of a joint return) to repay the subsidy in the form of a tax that shall not exceed the phase-in percentage (as defined). Allows high-income individuals to waive their right to premium assistance. Prohibits a credit from being allowed against this tax. Requires the Secretary of the Treasury to issue regulations or guidance to carry out this subsection. The provisions of this subsection apply to taxable years ending after the date of the enactment of this Act. [Sec. 3001]
Trade Adjustment Assistance (TAA) Health Coverage Improvement	<p><i>Includes a Definition of Firm Under the Trade Act</i> – Defines the term “firm” to include an agricultural firm, service sector firm, or public agency, or an appropriate subdivision thereof. This definition outlines the categories of workers who are eligible to apply for adjustment assistance.</p> <p><i>Improvement of the Affordability of the Health Coverage Tax Credit (HCTC)</i> – Temporarily increases the HCTC subsidy from 65% to 80% of the premium cost for private health insurance, applicable to coverage months beginning on or after the first day of the first month beginning 60 days after enactment. Limits increase in subsidy to eligible coverage months beginning before January 1, 2011. [Sec.</p>

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	<p>1899A]</p> <p><i>Payments for Monthly Premiums Paid Prior to Commencement of Advance Payments of Credit</i> – Requires the Secretary to make one or more retroactive payments on behalf of a certified individual in an aggregate amount equal to 80% of the premiums for the taxpayer and qualifying family members. Such retroactive payments apply to eligible months occurring prior to the first month for which an advance payment is made on behalf of such individual, for eligible coverage months beginning after December 31, 2008, and ending before January 1, 2011. Instructs the Secretary to not make any payments under this section until after six months after the date of enactment of this Act. [Sec. 1899B]</p> <p><i>TAA Recipients Not Enrolled in Training Programs Eligible for Credit</i> – Defines “eligible TAA recipient” to include any individual who is receiving a trade readjustment allowance under chapter 2 of title II of the Trade Act of 1974, or who would be eligible to receive such benefits if section 231 of the Trade Act of 1974 were applied without regard to subsection (a)(3)(b). For eligible coverage months beginning after the enactment of this Act and before January 1, 2011, defines the term “eligible TAA recipient” to include any individual who is receiving trade adjustment allowance, would receive such allowance except the individual is in a break of training, or is receiving unemployment compensation. [Sec. 1899C]</p> <p><i>TAA Pre-Certification Period Rule for Purposes of Determining Whether There is a 63-Day Lapse in Creditable Coverage</i> – In the case of a TAA-eligible individual - the period that begins on the day the individual has a TAA-related loss of coverage and ending on the date that is 7 days after the date of issuance by the Secretary (or by any person or entity designated by the Secretary) of a qualified health insurance costs credit eligibility certificate for such individual for purposes of section 7527 of the IRC - shall not be taken into account when determining the continuous period. Applicable to plan years beginning after the date of enactment. [Sec. 1899D]</p> <p><i>Continued Qualification of Family Members After Certain Events</i> – Allows dependants of HCTC-eligible individuals to retain eligibility for the health care tax credit (HCTC) for 24 months after the eligible individual become eligible for Medicare, dies, or finalizes a divorce, should the triggering event occur in an eligible coverage month beginning before January 1, 2011. Extends the eligibility period for family members for the HCTC and also the advanced payment of such credit, as described under Section 1899B. [Sec. 1899E]</p> <p><i>Extension of COBRA Benefits for Certain TAA-Eligible Individuals and PBGC Recipients</i> – Creates special rules for certain PBGC recipients and TAA-eligible individuals to extend the COBRA period of continuation coverage through December 31, 2010.</p> <ul style="list-style-type: none"> • For those covered employees who have been terminated from their employment (or have received a reduction in hours) and have a nonforfeitable right to a benefit under the PBGC, such COBRA benefits shall not be subject to the 18 month (or 36 month) limitation of continuation coverage; in the case of the death of a covered employee, COBRA benefits shall extend for 24 months for the surviving spouse or dependent children. In no case shall the period of coverage extend beyond December 31, 2010. • For those covered employees who have been terminated from their employment (or have received a reduction in hours) and are TAA-eligible, such COBRA benefits shall not be subject to the 18 month (or 36 month) limitation of continuation coverage. In no case shall the period of coverage extend beyond December 31, 2010. [Sec. 1899F] <p><i>Survey and Report on Enhanced Health Coverage Tax Credit Program</i> – Requires the Secretary of the Treasury to conduct a biennial study on the HCTC-eligible population and, no later than December 31 of each year in which a survey is conducted, report the findings to the Senate HELP and Finance Committees and House Ways & Means, Education & Labor, and Energy & Commerce Committees. No</p>

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	<p>later than October 1 of each year (beginning in 2010), the Secretary of the Treasury (after consultation with the Secretaries of HHS and Labor) shall report to these same committees information on eligible individuals, available plans, premiums, take-up rates, and reasons that individuals accept/reject coverage with respect to the most recent taxable year ending before such date. [Sec. 1899I]</p> <p><i>Appropriations</i> – Appropriates \$80,000,000 for fiscal years 2009 and 2010 to implement the amendments made by, and the provisions of, section 1899 through 1899I of this part. [Sec. 1899J]</p> <p><i>Extension of National Emergency Grants</i> – Declares that emergency funding is available for certain purposes related to state Trade Adjustment Assistance programs. Authorizes the Secretary of Labor to disperse such funds to states in order to:</p> <ul style="list-style-type: none"> • provide an eligible individual (an eligible PBGC pension recipient, as defined in section 35 (c)(4) of title 26) and qualifying family members with health insurance coverage for the 3-month period that immediately precedes the first eligible coverage month in which such eligible individual is covered by qualified health insurance. Requires that qualified health insurance meet the requirements of clauses (i) through (v) of section 35(e)(2)(A) of the Internal Revenue Code of 1986 (guarantee issue, no imposition of preexisting condition exclusion, and the total premium and benefits may not be greater than the total premium and benefits for a similarly situated individual who is not a qualifying individual (i.e. some level of community rating)); • assist an eligible individual and qualifying family members with enrolling in health insurance coverage and qualified health insurance or paying premiums for such coverage or insurance; • pay the administrative expenses incurred by the state related to the enrollment of eligible individuals and qualifying family members, including eligibility verification activities, notification to eligible individual, processing qualified health insurance costs credit eligibility certificates, among other administrative expenses; • perform outreach efforts to inform eligible individuals of the available health insurance and qualified health insurance options; and • provide bridge funding to assist potentially eligible individuals with purchasing qualified health insurance coverage prior to issuance of a qualified health insurance costs credit eligibility certificate and commencement of advance payment, and receipt of expedited payment. <p>Appropriates \$150,000,000 for fiscal years 2009-2010. [Sec. 1899K]</p> <p><i>GAO Study and Report</i> – Requires the Comptroller General to conduct a study of the health insurance tax credit allowed under section 35 of the IRC of 1986 and submit a report to Congress by March 1, 2010. Such report must include the administrative costs to the Federal government and the providers of qualified health insurance; the health status and relative risk status of eligible individuals and qualifying family members covered under such insurance; survey information regarding eligible individuals and their qualifying members; and the extent to which eligible individuals obtained health insurance other than qualifying health insurance or went without health insurance coverage. Grants the Comptroller authorization to examine and copy all documents, records, and other recorded information within the possession or control of providers of qualified health insurance and those records and documents determined by the Comptroller to be relevant to the study. Requires the Comptroller to not disclose the identity of any provider of qualified health insurance or any eligible individual in making any information obtained under this section available to the public. [Sec. 1899L]</p>
Social Security Administration Limitation on Administrative	<p><i>Appropriations to the Social Security Administration (SSA)</i> – Appropriates \$400,000,000 to the SSA for the construction and associated costs to establish a new National Computer Center. Appropriates \$500,000,000 for processing disability and retirement workloads; provides that up to \$40,000,000 may be used by the Commissioner for health information technology research and activities to facilitate the adoption of electronic medical records in disability claims, including the transfer of funds to the “Supplemental Security Income</p>

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Expenses	Program” to carry out activities under section 1110 of the Social Security Act (related to making grants available to the states for certain initiatives). [Title IX]
Relevant HIT Definitions	<p>The term “certified EHR technology” means a qualified electronic health record which is certified as meeting adopted standards.</p> <p>The term “health care provider” means a hospital; skilled nursing facility; nursing facility; home health entity or other long term care facility; health care clinic; community mental health center; renal dialysis facility; blood center; ambulatory surgical center; emergency medical services provider; federally qualified health center; group practice; a pharmacist; pharmacy; laboratory; physician; practitioner; a provider operated by, or in contract with, the Indian Health Service or by an Indian tribe, tribal organization, or urban Indian organization; a rural health clinic; a covered entity; an ambulatory surgical center; a therapist; and any other facility, entity, practitioner, or clinician determined appropriate by the Secretary.</p> <p>The term “health information” has the meaning given in section 1171(4) of the SSA.</p> <p>The term “health information technology” includes hardware, software, integrated technologies and related licenses, intellectual property, upgrades, or packaged solutions sold as services that are designed for or support the use by health care entities or patients for the electronic creation, maintenance, access, or exchange of health information.</p> <p>The term “health plan” has the meaning given in section 1171(5) of the SSA.</p> <p>The term “individually identifiable health information” has the meaning given in section 1171(6) of the SSA.</p> <p>The term “qualified electronic health record” means an electronic record of health-related information on an individual that includes patient demographic and clinical health information, such as medical history and problem lists; and has the capacity to: provide clinical decision support, support physician order entry, capture and query information relevant to health care quality, and exchange electronic health information with, and integrate such information from other sources.</p> <p>[Sec. 3000]</p>
Office of the National Coordinator for Health Information Technology (ONCHIT)	<p>Establishes the Office of the National Coordinator of Health Information Technology (ONCHIT) in the Department of Health and Human Services (HHS). ONCHIT shall be headed by a National Coordinator, who is appointed by and reports to the Secretary, and shall strive to develop a nationwide interoperable health information technology (HIT) infrastructure.</p> <p>Duties of the National Coordinator include:</p> <ul style="list-style-type: none"> • reviewing and determining if the standards, implementation specifications, and certification criteria for the electronic exchange and use of health information recommended by the HIT Standards Committee should be endorsed; • reporting such endorsement decisions to the Secretary no later than 45 days after receipt; • reviewing federal HIT investments to ensure that programs are meeting the objectives of the strategic plan; • ensuring that HIT policies and programs of the Department are coordinated with those of other relevant federal agencies;

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	<ul style="list-style-type: none"> • maintaining and updating, in consultation with other federal agencies [including the National Institute of Standards and Technology (NIST)], a strategic plan with measurable outcome goals, specific objectives, milestones, and metrics for: <ul style="list-style-type: none"> ○ the electronic exchange and use of health information and the enterprise integration of such information, ○ the utilization of an electronic health record for each person in the U.S. by 2014, ○ the incorporation of privacy protection for the electronic exchange of an individual’s individually-identifiable health information, ○ ensuring security methods to ensure appropriate authorization and electronic authentication of health information, ○ specifying a framework for coordination and flow of recommendations and policies among the Secretary, the National Coordinator, the HIT Policy Committee, the HIT Standards Committee, and other entities, ○ methods to foster public understanding of HIT, and ○ strategies to enhance the use of HIT in improving the quality of health care, reducing errors and disparities, improving public health and increasing presentation and coordination with community resources, and improving continuity of care, ○ specific plans for ensuring that populations with unique needs, such as children, are appropriately address in the technology design which may include technology that automates enrollment and retention; • maintaining a website containing information on work, schedules, reports, recommendations, and other information to ensure transparency; • keeping or recognizing, in consultation with the Director of NIST, a program for the voluntary certification of HIT as being in compliance with applicable certification criteria; • preparing reports/publications addressing: 1) any additional funding or authority needed; 2) lessons learned from major public and private health care systems and their uses of HIT; 3) the impact of HIT in communities with health disparities and in areas with uninsured, underinsured, and medically underserved individuals, and the use of HIT to reduce and better manage chronic diseases; and 4) evidence on the benefits and costs of HIT; • estimating and publishing resources required annually to reach the goal of utilization of an EHR for each person in the U.S. by 2014, including: the required level of federal funding; expectations for regional, state, and private investment; expected volunteer contributions; and resources needed to establish a HIT workforce sufficient to support this effort (including education programs in medical informatics and health information investment); • providing financial assistance to consumer advocacy groups and non-profit entities that work in the public interest to defray costs of participating under the National Technology Transfer Act of 1995; • establishing a governance mechanism for the nationwide health information network; • detailing, with or without reimbursement, any federal personnel to the Office to assist it in carrying out its duties; and • appointing a Chief Privacy Officer within ONCHIT who will advise the National Coordinator on privacy, security, and data stewardship of electronic individually identifiable health information, and will coordinate with other federal agencies, state efforts, and foreign countries on these fronts. <p>[Sec. 3001]</p>
Health IT Policy Committee	<p>Establishes a HIT Policy Committee to:</p> <ul style="list-style-type: none"> • make policy recommendations relating to the implementation of a nationwide HIT infrastructure to the National Coordinator;

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	<ul style="list-style-type: none"> • create a recommended policy framework for the development and adoption of a nationwide HIT system consistent with the Coordinator’s strategic plan, to be updated as appropriate; • recommend areas in which standards, implementation specifications, and certification criteria are needed, and recommend an order of priority for the development of these standards in the following areas: <ul style="list-style-type: none"> ○ technologies that protect the privacy of health information and promote security in a qualified EHR, including the segmentation and protection of disclosure of specific and sensitive individually identifiable health information, ○ a nationwide interoperable HIT infrastructure, including the utilization of a certified EHR for each person in the U.S. by 2014, ○ technologies as part of a qualified EHR that allow for accounting of disclosures of treatment, payment, and health care operations, ○ the use of certified EHRs to improve the quality of health care, ○ 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 the secured, physical perimeter of a health care provider, health plan, or health care clearinghouse, ○ the use of electronic systems to ensure the comprehensive collection of patient demographic data, ○ technologies that address the needs of children and other vulnerable populations; • potentially consider 1) HIT infrastructure uses for collecting quality data and public reporting, bio-surveillance, drug safety, and telemedicine, among other areas , 2) methods to facilitate secure access by an individual to his or her protected information, and 3) 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; and • serve as a forum for broad stakeholder input with specific expertise in policies relating to these areas. <p>The Policy Committee shall ensure that recommendations made are consistent with the evaluation conducted under section 1809(a) of the SSA (MIPPA).</p> <p>The Policy Committee shall be composed of members to be appointed as follows:</p> <ul style="list-style-type: none"> • 3 members appointed by the Secretary, 1 of whom shall be appointed to represent the Department of HHS and 1 of whom shall be a public health official; • 1 member appointed by each of the following: the Senate Majority Leader, the Senate Minority Leader, the Speaker of the House of Representatives, the House Minority Leader; • Such other members as shall be appointed by the President as representatives of other relevant federal agencies; and • 13 members appointed by the Comptroller General, of whom 3 shall represent patients or consumers, 2 shall represent health care providers (1 of which shall be a physician), 1 shall be from a labor organization representing health care workers, 1 shall be from the research community, 1 shall have expertise in privacy and security, 1 shall have expertise in improving the health of vulnerable populations, 1 shall represent health plans or third party payers, 1 shall represent IT vendors, 1 shall represent purchasers or employers, and 1 shall have expertise in health care quality measurements and reporting. <p>The Policy Committee shall ensure adequate opportunity for the participation of outside advisors with expertise in relevant areas,</p>

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	<p>including individuals with expertise in the development of policies for the electronic exchange and use of health information, including in the areas of privacy and security.</p> <p>The National Coordinator shall ensure that pertinent recommendations and comments from the National Committee on Vital and Health Statistics (NCVHS) are also considered.</p> <p>The Federal Advisory Committee Act (5 U.S.C. App.), other than section 14 of such Act, shall apply to the Policy Committee.</p> <p>The Secretary shall provide for the publication in the <i>Federal Register</i> and the posting on ONCHIT website of all policy recommendations made by the Policy Committee.</p> <p>[Sec. 3002]</p>
Health IT Standards Committee	<p>Establishes an HIT Standards Committee to:</p> <ul style="list-style-type: none"> • recommend to the National Coordinator standards, implementation specifications, and certification criteria for HIT consistent with the Coordinator’s strategic plan; • update standards, implementation specifications, and certification criteria for HIT that have been previously developed, and make new recommendations as appropriate; • 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; • provide for the pilot testing of standards and implementation specifications by NIST during their development, harmonization, or recognition; • serve as a forum for broad stakeholder input in the development, harmonization, and recognition of standards; • no later than 90 days after enactment, develop a schedule for assessment of policy recommendations developed by the HIT Policy Committee, to be updated annually; • conduct open public meetings and develop a process to allow for public comment on the schedule and recommendations; and • ensure that relevant recommendations from NCVHS are considered in the development of standards (a responsibility delegated to the National Coordinator). <p>The Standards Committee’s membership shall be comprised of 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 the electronic exchange and use of HIT. Members of the Standards Committee shall represent a balance among various sectors of the health care system. The Policy Committee shall ensure an opportunity for the participation 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.</p> <p>The Secretary may provide or ensure that financial assistance is provided by the Standards Committee to defray in whole or in part any membership dues/fees charged by the Committee to those consumer advocacy groups and non-profit entities that work in the public interest.</p> <p>The Federal Advisory Committee Act (5 U.S.C. App.), other than section 14 of such Act, shall apply to the Committee.</p>

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	<p>The Secretary shall provide for the publication in the <i>Federal Register</i> and the posting on ONCHIT website all recommendations made by the Standards Committee.</p> <p>[Sec. 3003]</p>
Process for Adoption of Endorsed Recommendations; Adoption of Initial Set of Standards, Implementation Specifications, and Certification Criteria	<p>No later than 90 days after the receipt of endorsed standards, implementation specifications, and certification criteria, the Secretary, in consultation with representatives of other relevant federal agencies, shall jointly review to determine whether or not to propose adoption. The Secretary may decide to propose adoption of a standard, specification, or criteria by regulation. If the Secretary decides not to adopt an item, the Secretary will notify the National Coordinator and the HIT Standards Committee in writing with the reasons for non-endorsement.</p> <p>The Secretary will provide for the publication in the <i>Federal Register</i> of all determinations.</p> <p>Not later than December 31, 2009, the Secretary shall, through the rulemaking process, adopt an initial set of standards, implementation specifications, and certification criteria. The rulemaking for the initial set of standards, implementation specifications, and certification criteria may be issued on an interim, final basis.</p> <p>The standards, implementation specifications and certification criteria adopted before the date of enactment through the process through the ONCHIT may be applied towards meeting this requirement.</p> <p>The Secretary shall adopt additional standards, implementation specifications, and certification criteria as necessary and consistent with the published schedule.</p> <p>[Sec. 3004]</p>
Voluntary Application and Use of Adopted Standards and Implementation Specifications by Private Entities	<p>Nothing in the Act shall be construed to require a private entity to adopt or comply with an adopted standard or implementation specification; or 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 standard or specification.</p> <p>Nothing in this section shall be construed to require that a private entity that contracts with the federal government apply or use the adopted standards and implementation specifications with respect to activities unrelated to the contract.</p> <p>[Sec. 3006]</p>
Federal Health Information Technology	<p>The National Coordinator shall support the development and routine updating of qualified EHR technology and make available such qualified EHR technology unless the Secretary determines through an assessment that the needs and demands of providers are being substantially and adequately met through the marketplace. In making such technology publicly available, the National Coordinator shall ensure that the technology is certified to be in compliance with applicable standards.</p>

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	<p>The National Coordinator may impose nominal fees for the adoption of a HIT system by providers, taking into account their financial circumstances.</p> <p>[Sec. 3007]</p>
Transitions	<p><i>ONCHIT</i> – All functions, personnel, assets, liabilities, and administrative actions applicable to the National Coordinator appointed under Executive Order 13335 or the Office of such National Coordinator on the date before the date of enactment shall be transferred to ONCHIT upon enactment.</p> <p><i>National eHealth Collaborative</i> – Nothing shall be construed as prohibiting the AHIC Successor, Inc. doing business as the National eHealth Collaborative from modifying its charter, membership, duties, and any other structure/function required to be consistent with the requirements of a voluntary consensus-setting body so as to allow the Secretary to recognize the AHIP Successor, Inc. as the HIT Policy or Standards Committee.</p> <p>Until recommendations are made by the Policy Committee, the Standards Committee’s recommendations shall be consistent with the most recent recommendations made by such AHIC Successor, Inc.</p> <p>[Sec. 3008]</p>
Miscellaneous Provisions	<p>This title may not be construed as having any effect on the Secretary’s authorities under HIPAA privacy and security law, and ensures that the HIT standards and implementation specifications adopted take into account the Law’s requirements.</p> <p>In administering the provisions, the Secretary shall have flexibility in applying the definition of “health care provider,” including the authority to omit certain entities listed in such definition where appropriate.</p> <p>[Sec. 3009]</p>
Authorization of Appropriations	<p>Appropriates \$2,000,000,000 to ONCHIT to carry out Title XIII of the Act, to be available until expended.</p>
Coordination of Federal Activities with Adopted Standards and Implementation Specifications	<p>As each agency(as defined by the Office of Management and Budget, in consultation with the Secretary) implements, acquires, or upgrades HIT systems used for the direct exchange of individually identifiable health information between agencies and with non-federal entities, it shall use, where available, HIT systems and products that meet standards and implementation specifications adopted by the Secretary. Within 3 years of adoption of a standard or specification, the President shall take steps to ensure that federal activities surrounding the collection and submission of health information are consistent with such measures. [Sec. 13111]</p>
Application to Private Entities	<p>Each agency shall require in contracts/agreements with providers, health plans, or health insurance issuers that as each provider, plan, or issuer implements, acquires, or upgrades HIT systems, it shall utilize, where available, HIT systems and products that meet adopted standards and specifications. [Sec. 13112]</p>
Study and Reports	<p><i>Report on Adoption of Nationwide System</i> – No later than 2 years after enactment and annually thereafter, the Secretary shall submit to the appropriate committees of jurisdiction of the House and Senate a report that describes actions that the federal government and private entities have taken to facilitate the adoption of a nationwide HIT system, describes barriers to adoption, and contains recommendations to achieve full implementation.</p>

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	<p><i>Reimbursement Incentive Study and Report</i> – The Secretary shall carry out (or contract with a private entity to carry out) a study examining methods for creating efficient reimbursement incentives for improving quality in federally qualified health centers, rural clinics, and free clinics. No later than 2 years after enactment, the Secretary shall report on the study to the appropriate committees of jurisdiction of the House and Senate.</p> <p><i>Aging Services Technology Study and Report</i> – The Secretary shall carry out (or contract with a private entity to carry out) a study of matters relating to the potential use of new aging services technology to assist seniors, individuals with disabilities, and caregivers through the aging process. This study shall include an evaluation of methods of technology that can be used to meet the needs of this population, methods for fostering technological innovation within the business and academic communities, and developments in aging services technology abroad; and identification of barriers to innovation and to the adoption of a strategy for removal of those barriers by providers and consumers. No later than 24 months after enactment, the Secretary shall report on the study to the appropriate committees of jurisdiction of the House and Senate.</p> <p>[Sec. 13113]</p>
NIST Testing	<p>In coordination with the HIT Standards Committee, the Director of NIST shall test standards and implementation specifications to assure efficient implementation and use. In coordination with the HIT Standards Committee, the Director of NIST shall support the establishment of a conformance testing infrastructure, including the development of technical test beds. The development may include a program to accredit independent, non-federal laboratories to perform testing. [Sec. 13201]</p>
Research and Development Programs	<p>The Director of NIST, 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 to establish multidisciplinary Centers for Health Care Information Enterprise Integration, which would generate innovative approaches to health care information enterprise integration and the development and use of HIT. Research areas may include: interfaces between human information and communication technology systems, voice-recognition systems, software that improves interoperability and connectivity, software dependability in systems critical to health care delivery, measurement of the impact of IT on the quality and productivity of health care, health information enterprise management, HIT security and integrity, and relevant HIT to reduce medical errors. An institution seeking funding must submit an application describing the research projects to be undertaken, methods for the Center to promote collaboration between disciplines, technology transfer activities to demonstrate and diffuse research results, and how the Center will contribute to the training and education of researchers.</p> <p>The National High-Performance Computing Program (established in section 101 of the High-Performance Computing Act of 1991) shall include federal research and development programs related to the deployment of HIT.</p> <p>[Sec. 13202]</p>
Immediate Funding to Strengthen the Health Information	<p>Authorizes the Secretary, using the funds to be appropriated as necessary for FY 2009-2013, to invest in the infrastructure necessary to allow for and promote the electronic exchange and use of health information consistent with the National Coordinator’s strategic plan. The Secretary shall invest funds through agencies with expertise in such goals [such as ONCHIT, the Health Resources and Services Administration, the Agency for Healthcare Research and Quality (AHRQ), Centers of Medicare and Medicaid Services (CMS), the Centers for Disease Control and Prevention, and the Indian Health Service] to support:</p>

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Technology Infrastructure	<ul style="list-style-type: none"> • HIT architecture that will support the nationwide electronic exchange and use of HIT 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 HHS to support the electronic use and exchange of health information; • Development and adoption of appropriate certified EHRs for categories of providers not eligible for support under title XVIII or XIX of the SSA; • Training on and dissemination of information on best practices to integrate HIT (including EHRs) into a provider’s delivery of care, consistent with best practices learned from the Health Information Technology Research Center, including community health centers receiving assistance under section 330, covered entities under section 340B, and providers participating in 1 or more of the programs under titles XVIII, XIX, and XXI of the SSA (relating to Medicare, Medicaid, and SCHIP); • Infrastructure and tools for the promotion of telemedicine, including coordination among federal entities; • Promotion of interoperability of clinical data repositories or registries; • Promotion of technologies and best practices that enhance the protection of health information; and • Improvement and expansion of use of HIT by public health departments. <p>To the greatest extent practicable, the Secretary shall ensure that where funds are expended for the acquisition of HIT, such funds shall be used to acquire HIT that meets applicable standards. Where this is not practicable, the Secretary shall ensure that such HIT meets applicable standards otherwise adopted by the Secretary.</p> <p>[Sec. 3011]</p>
Health Information Technology Implementation Assistance	<p>To assist providers to adopt, implement, and effectively use certified EHR technology, the Secretary, acting through ONCHIT, shall establish an HIT extension program to provide HIT assistance service to be carried out through HHS. The National Coordinator shall consult with other federal agencies with demonstrated experience and expertise in IT services, such as NIST, in developing and implementing this program.</p> <p><i>Health Information Technology Research Center</i> – The Secretary shall create an HIT Research Center (“the Center”) to provide technical assistance and develop or recognize best practices to support and accelerate efforts to adopt, implement, and effectively utilize HIT. The Center shall incorporate input from other federal agencies with demonstrated experience and expertise in IT (e.g., NIST), users of HIT (e.g., providers and their support and clerical staff, and others involved in the care and care coordination of patients), and others as appropriate. The Center shall provide a forum for the exchange of knowledge/experience, accelerate the transfer of lessons learned from existing public and private sector initiatives, disseminate evidence and experience, provide technical assistance for the establishment and evaluation of regional and local health information networks to facilitate information exchange, provide technical assistance for the development and dissemination of solutions to barriers to exchange, and learn about effective strategies to adopt and utilize HIT in medically-underserved communities.</p> <p><i>Health Information Technology Regional Extension Centers</i> – The Secretary shall provide for the creation and support of 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 HIT. The objective of the regional centers is to enhance and promote the adoption of HIT through: 1) assistance with the implementation, effective use, upgrading, and ongoing maintenance of HIT (including EHRs) to</p>

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	<p>health care providers nationwide; 2) broad participation of individuals from industry, universities, and state governments; 3) active dissemination of best practices and research on the implementation, effective use, upgrading, and ongoing maintenance of HIT (including EHRs) to health care providers in order to improve the quality of care and protect the privacy and security of health information; 4) participation, to the extent practicable, in health information exchanges; 5) utilization, when appropriate, of the expertise and capability that exists in federal agencies other than the Department; and 6) integration of HIT (including EHRs) into the initial and ongoing training of health professionals and others in the health care industry that would be instrumental in improving the quality of care through the smooth and accurate electronic use and exchange of health information. Regional centers shall be affiliated with any U.S.-based nonprofit institution or organization that applies and is awarded assistance, giving priority to public or non-profit hospitals or critical access hospitals, federally qualified health centers, entities located in rural areas or areas that serve uninsured/underinsured/medically-underserved individuals, and individual or small group practices focused on primary care. Provisions relating to financial support, application review, and evaluation are detailed in the bill.</p> <p>[Sec. 3012]</p>
State Grants to Promote Health Information Technology	<p>The Secretary, acting through the National Coordinator, shall establish a program to facilitate and expand the electronic movement of HIT among organizations according to nationally-recognized standards. The Secretary may award grants to states or state-designated entities that submit applications per the Secretary’s specifications for purposes of planning and implementation. A plan submitted to the Secretary shall be pursued in the public interest, be consistent with the National Coordinator’s strategic plan, include a description of the ways the state or qualified state-designated entity will carry out its activities, and contain such elements as the Secretary may require.</p> <p>A “qualified state-designated entity” is an entity that: 1) is designated by the state as eligible to receive awards; 2) is a not-for-profit entity with broad stakeholder representation on its governing board; 3) demonstrates that one of its principal goals is to use IT 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 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.</p> <p>Amounts received through this program 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 activities that include: enhancing broad and varied participation in the nationwide electronic use and exchange of health information, identifying state/local resources available toward a nationwide effort to promote HIT, complementing other federal efforts toward the promotion of HIT, providing assistance for the development of solutions to barriers to the exchange of HIT, promoting effective strategies to adopt/utilize HIT in medically-underserved communities, assisting patients in utilizing HIT, encouraging clinicians to work with HIT Regional Extension Centers, supporting public health agencies’ authorized use of and access to electronic health information, promoting the use of EHRs for quality improvement, and such other activities specified by the Secretary.</p> <p>In carrying out activities with grant money, entities shall consult with and consider the recommendations of providers, health plans, patient/consumer organizations, HIT vendors, health care purchasers/employers, public health agencies, health professions schools, clinical researchers and other users of HIT and entities as determined appropriate by the Secretary. Each year, the Secretary shall evaluate the activities conducted and implement lessons so that subsequent awards are made in a manner that will result in the greatest improvement to the quality and efficiency of health care.</p>

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	<p>Beginning with FY 2011, for each fiscal year, the Secretary may not make a grant unless a state agrees to make available non-federal contributions toward the cost of a grant in an amount equal to: \$1 for every \$10 of federal funds in FY 2011, \$1 for every \$7 of federal funds in FY 2012, and \$1 for every \$3 of federal funds for FY 2013 and beyond. For fiscal years preceding 2011, the Secretary shall determine the appropriate non-federal contribution.</p> <p>[Sec. 3013]</p>
<p>Competitive Grants to States and Indian Tribes for the Development of Loan Programs to Facilitate the Widespread Adoption of Certified EHR Technology</p>	<p>The National Coordinator may award competitive grants to eligible entities, defined as a State or Indian Tribe, to establish programs for loans to providers to facilitate the purchase and use of HIT.</p> <p>To be eligible for a grant, an entity must:</p> <ul style="list-style-type: none"> • submit an application to the National Coordinator containing such information required by the National Coordinator; • submit to the National Coordinator a strategic plan (which identifies the intended uses of amounts available to the Loan Fund of such entity), with assurances that the entity will update the plan annually; • provide assurances to the National Coordinator that the entity will not provide a loan from the Loan Fund (established by the entity for the housing of grant money only) unless the provider agrees to submit reports on quality measures adopted by the federal government to the Administrator of CMS or the Secretary (depending on the nature of the entity), demonstrates the efficacy of the EHR supported by the loan money, complies with other requirements required by the Secretary, includes a long-term plan for maintenance and support by providers, and agrees to provide matching funds of \$1 for every \$5 of federal funds. <p>Amounts deposited in a Loan Fund shall be used only for awarding loans or loan guarantees, making reimbursements, or as a source of reserve and security for leveraged loans. Loans may be used by providers to facilitate the purchase of certified EHR technology, enhance the utilization of this technology (which may include costs associated with upgrading HIT so that it meets criteria necessary to be considered “certified EHR technology”), train personnel in its use, or improve the secure electronic exchange of health information. The bill contains specific requirements for the administration of Loan Funds. Loans Funds may accept contributions from private sector entities, except that such entities may not specify the recipient(s) of any loan issued; the entity shall make the identity of, and amount contributed by, any private sector entity publicly-available. An eligible entity may agree to reimburse a private sector entity for contributions made, but this amount shall not be greater than the principal amount of the contribution made.</p> <p>The Secretary may not make an award prior to January 1, 2010.</p> <p>[Sec. 3014]</p>
<p>Demonstration Program to Integrate Information Technology into Clinical Education</p>	<p>Authorizes competitive grants to carry out demonstration projects to develop academic curricula integrating qualified HIT systems into clinical education. Grants are to be awarded on a competitive basis and pursuant to peer review.</p> <p>To receive a grant, entities must submit an application; submit a strategic plan for integration of HIT in the clinical education program to the Secretary; be a 1) school of medicine, osteopathic medicine, dentistry, or pharmacy, or a graduate program in behavioral or mental health (or any other graduate health profession school), 2) a graduate school of nursing or physician assistant studies, 3) a consortium of 2</p>

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	<p>or more of these schools, or 4) an institution with a graduate medical education program in medicine, osteopathic medicine, dentistry, pharmacy, nursing, or physician assistance studies; provide for data collection regarding the effectiveness of the project; and provide matching funds. (The Secretary may not provide more than 50% of the costs of any activity, except in an instance of national economic conditions which would render cost-sharing requirements detrimental to the program and upon notification to Congress as to the justification of a waiver.)</p> <p>An eligible entity shall use amounts received under the grant in collaboration with 2 or more disciplines and to integrate qualified HIT into community-based clinical education. It shall not use funds for the purchase of hardware, software, or services.</p> <p>The Secretary shall take such action as may be necessary to evaluate the projects funded and publish, make available, and disseminate the results of such evaluations on as wide a basis as practicable.</p> <p>No later than 1 year after enactment (and annually thereafter), the Secretary shall submit to the Senate Finance and HELP Committees and the House Energy & Commerce Committee a report describing the specific projects established and recommendations for Congress based on the Secretary’s evaluation.</p> <p>[Sec. 3015]</p>
Information Technology Professionals on Health Care	<p>The Secretary, in consultation with the Director of NIST, shall provide assistance to institutions of higher education to establish or expand medical health informatics education programs to ensure rapid and effective utilization and development of HIT. Activities for which assistance may be provided may include developing/revising curricula in medical health informatics and related disciplines, recruiting/retaining students to the program, acquiring equipment necessary for student instruction, and establishing/enhancing bridge programs in health informatics fields. Priority shall be given to existing education and training programs, and programs designed to be completed in less than 6 months.</p> <p>[Sec. 3016]</p>
General Grant and Loan Provisions	<p>The Secretary may require that an entity receiving assistance submit a report no later than 1 year after receipt of the funds which includes an analysis of the effectiveness of the activities, as well as an analysis of the impact of the project on health care quality and safety. Each year, the Secretary shall evaluate the activities conducted and implement lessons learned in such a way that subsequent awards are made in a manner that will result in the greatest improvement to the quality and efficiency of health care. [Sec. 3017]</p>
Medicare Program- Incentives for the Adoption and Meaningful Use of Certified EHR Technology by Eligible Professionals	<p>Establishes incentive payments under the Medicare program for the adoption and meaningful use of certified EHR technology by “eligible professionals” [i.e. a physician as described in Sec. 1861(r) of the SSA] and hospitals.</p> <p>Incentive Payments for Eligible Professionals for the Adoption and Meaningful Use of EHR Technology</p> <p>An eligible professional (or an employer or facility) will receive incentive payments, in the amounts specified in the bill, for the first 5 years after adoption of the meaningful use of EHR technology and demonstrated performance during the reporting period for each applicable payment year. Provides a bonus for early adoption and meaningful use of EHRs in 2011 or 2012. The bill increases the incentive payment for an eligible professional from \$15,000 to \$18,000 if the “first payment year” is 2011 or 2012. Eligible professionals adopting meaningful use of EHRs after 2013 will only be eligible for incentive payments for 2 years after which time such</p>

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	<p>payments will be phased out. If an eligible professional predominantly furnished services under this Part in a rural 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%. An eligible professional who adopts the meaningful use of EHRs after 2016 is not eligible for incentive payments. The bill also provides that if the first payment year for an eligible professional’s adoption and meaningful use of EHR would be 2014 then the payment for that year and any subsequent year would be \$0. For the purpose of this subsection, the term “payment year” means a year beginning with 2011. The first payment year means, with respect to covered services furnished by an eligible professional, the first year for which an incentive payment is made for such services under this subsection.</p> <p><i>Exclusion of Hospital-Based Eligible Professional from Incentive Payments</i> – Hospital-based eligible professionals are excluded from incentive payments under this section. For the purposes of the exclusion, “hospital-based professional” means a 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 computer equipment of the hospital. A hospital-based eligible professional is determined on the basis of the site of service and without regard to any employment or billing arrangement between the eligible professional and any other provider.</p> <p><i>Meaningful Use of EHRs</i> – To receive an incentive payment, an eligible professional, except for a hospital-based eligible professional, who furnishes “covered professional services” during a EHR reporting period in a payment year must demonstrate, to the satisfaction of the Secretary, the fulfillment of the following requirements:</p> <ul style="list-style-type: none"> i) <i>Meaningful Use of Certified EHR Technology</i> – 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) <i>Information Exchange</i> – During the reporting period such certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to exchange of health information to improve the quality of health care, such as promoting care coordination; iii) <i>Reporting on Measures Using EHRs</i> – 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 publish in the <i>Federal Register</i> such measures and provide a public comment period on their use. <p>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 furnishing covered professional services in a group practice. The bill directs the Secretary to 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. The Secretary may not require the electronic reporting of information on clinical quality measures unless the Secretary has the capacity to accept the information electronically, which may be on a pilot basis.</p> <p><i>Certified EHR Technology</i> – For the purpose of this section, the term “certified EHR technology” means a qualified electronic health record [as defined in 3000 (13) of the PHSA] 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 type of record involved.</p> <p><i>Demonstration of Meaningful Use of EHRs</i> – An eligible professional must demonstrate that he or she has satisfied requirements of</p>

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	<p>meaningful EHR use through means specified by the Secretary. Such measures may include the following:</p> <ul style="list-style-type: none"> i) an attestation; ii) the submission of claims with appropriate coding; iii) a survey response; iv) reporting on measures using EHR; and v) other measures as specified by the Secretary. <p>Includes a posting on the CMS website, in an easily-understandable format, a list of names, business addresses, and business phone numbers of eligible professionals who are meaningful EHR users and, as determined appropriate by the Secretary, of group practices receiving incentive payments.</p> <p><i>Coordination with Medicaid</i> – The Secretary shall attempt to avoid duplicative federal and state requirements governing the demonstration of meaningful use of certified EHR technology, including allowing satisfaction of state requirements for meaningful use of EHR to be deemed as fulfillment of the federal requirements. Additionally, the Secretary may adjust the reporting periods under this section to avoid duplication of requirements.</p> <p><i>Use of Part D Data</i> – The Secretary may, notwithstanding sections 1860D-15(d)(2)(B) and 1860D-15(f)(2), use data regarding drug claims submitted for the purposes of section 1860D-15 that are necessary for the purposes of establishing that an eligible professional is a meaningful user of EHR during a reporting period for a payment year.</p> <p><i>Penalty-Reduction in Fee Schedule Payment</i> – Provides for a reduction in the fee schedule payment for covered professional services furnished during 2015 and any subsequent payment year by an eligible professional who is not a meaningful user of EHR during a reporting period for the year. The reduction in the fee schedule is as follows: for payment year 2015- 99%; for payment year 2016 - 98%; and for payment year 2017 and each subsequent years - 97%. For 2018 and subsequent years, the Secretary has the authority to decrease the applicable percent of reduction upon a finding that the proportion of eligible professionals who are EHR users is less than 75%, 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 percentage of reduction be less than 95%.</p> <p><i>Hardship Exception</i> – Under a hardship exception created under the bill, the Secretary may exempt an eligible professional from the application of the payment reduction upon a determination, subject to annual renewal, that compliance with the requirement for being a meaningful EHR user would result in significant hardship, such as in the case of an eligible professional who practices in a rural area without sufficient internet access. An eligible professional may not be granted an exemption for more than 5 years.</p> <p>Incentives for Certain MA-Affiliated Eligible Professionals</p> <p>Establishes an incentive payment for “qualified” Medicare Advantage (MA) organizations to receive payment for the meaningful use of certified EHR technology by eligible professionals and hospitals. A qualified MA organization is an organization that is organized as a health maintenance organization (HMO) as defined in section 2791(b)(3) of the Public Health Service Act.</p>

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Application of Eligible Professionals Incentives for Certain MA Organizations for Adoption and Meaningful Use of Certified EHR Technology – This section applies incentive payments for eligible professionals to a qualified MA organization. In the case of a qualified MA organization the provisions of sections 1848(o) and 1848(a)(7) shall apply with respect to eligible professionals of the organization who attests under section 1854(a)(1)(A)(iv) to be meaningful EHR users in a similar manner as they apply to eligible professionals under such sections.

Eligible professionals are professionals who are employed by the MA organization, or employed by, or are partners of an entity that through a contract with the MA organization furnishes at least 80% of the entity’s patient care services to enrollees of such organization; and furnishes at least 80% of the professional services of the eligible professional to enrollees of the organization; and furnishes on average at least 20 hours per week of patient care services.

Instead of the incentive payment amount provided under the eligible professionals incentive payment in section 1848 (o)(1)(A) as established under this bill, the Secretary may substitute an amount that s/he determines to the extent practicable and feasible, 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. In order to avoid duplication of payments, if an eligible professional (as described in this subsection) is entitled to the maximum incentive payment under section 1848(o)(1)(a) and payment under this subsection for the same reporting period, then the incentive payment will only be made under section 1848(o)(1)(a). If an eligible professional described in this subsection 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). Additionally, if an eligible professional is entitled to an incentive under section 1848 (o)(1)(a) other than the maximum amount and also meets the requirements for incentive payments under this subsection, 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); and to collect data from MA organizations to ensure against such duplicate payments.

Penalty-Payment Adjustment – Provides for a reduction of payment for a qualified MA organization who attests that not all eligible professionals are meaningful EHR users with respect to a year beginning fiscal year 2016 and subsequent years. Instead of a reduction of an applicable percentage of the fee schedule amount for a year, the payment reduction for the MA organization shall be equal to 100% minus a number of percentage points equal to the product of the number of percentage points by which the applicable percent [under section 1848 (a)(7)(A)(ii)] for the year is less than 100 %; and the Medicare physician expenditure proportion specified in subparagraph (C) for the year. 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. The Secretary shall apply the payment adjustment under this paragraph based on the proportion of such eligible professionals that are not meaningful EHR users for such year.

Meaningful EHR User Attestation with Bids – 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 the submission of the initial bid under section 1854(a)(1)(A)(iv), identifying whether each eligible professional described in paragraph (2) with respect to such organization is a meaningful EHR user [as defined in section 1848(o)(3)] for a year specified by the Secretary; and 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

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	<p>period specified by the Secretary.</p> <p>Includes a posting on the CMS website, in an easily-understandable format, a list of names, business addresses, and business phone numbers of each qualifying MA organization receiving an incentive payment under the subsection for eligible professionals of the organization; and the eligible professionals of the organization for which such incentive payment is based.</p> <p><i>Limitation on Review</i> — Restricts administrative or judicial review under section 1869, section 1878, or otherwise, of the methodology and standards for determining: 1) payment amounts and payment adjustments under this subsection, including avoiding duplication of payments and the specification of rules for the fixed schedule for application of limitation on incentive payments for all eligible professionals; 2) eligible professionals and a meaningful EHR user under section 1848(o)(C), 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).</p> <p><i>Study and Report Relating to MA Organizations</i> — Includes a study conducted by the Secretary of HHS on the extent to which and manner in which payment incentives and adjustments could be made available to professionals, who are not eligible for HIT incentive payments under section 1848(o) and receive payments for Medicare patient services nearly-exclusively through contracted arrangements with one or more MA organizations or organizations with contracts with MA organizations. The study will determine 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 MA organizations or intermediary organizations. The report is to be submitted by the Secretary of HHS to Congress no later than 120 days after the date of the enactment of this Act.</p> <p><i>Conforming Amendments to E-Prescribing</i> – Amends section 1848 to provide a limitation with respect to EHR incentive payments by adding a new subparagraph D that establishes that 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 reporting period the eligible professional or group practice receives an incentive payment under subsection (o)(1)(A) with respect to certified EHR technology (as defined in subsection (o)(6)(A)) that has the capability of electronic prescribing.</p> <p>Incentives for Hospitals</p> <p>Amends section 1886 of the SSA to establish an incentive payment for hospitals similar to that provided to eligible professionals for the meaningful use of EHRs with respect to inpatient hospital services furnished by an eligible hospital during a payment year for the reporting period with respect to such year. The incentive amount is based on a formula provided in the bill. The first applicable payment year for the incentive for meaningful EHR use is 2011. An eligible hospital that first adopts EHRs after 2013 will only be eligible for incentive payments for 2 years after which time such payments will be phased out. An eligible hospital who adopts the meaningful use of EHRs after 2015 is not eligible for incentive payments.</p> <p>For the purpose of the payment incentive, a hospital must demonstrate, to the satisfaction of the Secretary, the fulfillment of the following requirements:</p> <ul style="list-style-type: none"> i) Meaningful Use of Certified EHR Technology – The hospital 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;

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	<p>ii) Information Exchange – During the reporting period such certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to exchange of health information to improve the quality of health care, such as promoting care coordination;</p> <p>iii) Reporting on Measures Using EHRs – 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). Prior to the selection of measures for the purposes of applying this subsection, the Secretary shall publish in the <i>Federal Register</i> such measures and provide a public comment period on their use. Additionally, the Secretary shall, to the extent possible, select the same measures for purposes of subparagraph (A)(III) as are selected for quality purposes under Title XIX, which provides grants to states for medical programs.</p> <p>Includes a posting on the CMS website, in an easily-understandable format, a list of names of the eligible hospitals that are meaningful EHR users and other relevant data as determined by the Secretary.</p> <p>The Secretary may not require the electronic reporting of information on clinical quality measures unless the Secretary has the capacity to accept the information electronically, which may be on a pilot basis. A hospital can satisfy the demonstration requirements through means specified by the Secretary. Such measures may include the following:</p> <ul style="list-style-type: none"> i) an attestation; ii) the submission of claims with appropriate coding; iii) a survey response; iv) reporting on measures using EHR; or v) other measures as specified by the Secretary. <p>Includes an amendment to section 1861 of the SSA to include critical access hospitals within the definition of “eligible hospital” for the purpose of applying incentive payments for the adoption and meaningful use of EHRs.</p> <p><i>Penalty-Market Basket Adjustment</i> – For fiscal year 2015 and each subsequent year, in the case of an eligible hospital that is not a meaningful EHR user for the 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 % for fiscal year 2015; 66 2/3 % for fiscal year 2016; and 100% 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. The bill provides for a hardship exception, under which the Secretary may exempt an eligible hospital from the application of the payment reduction upon a determination, subject to annual renewal, that compliance with the requirement for being a meaningful EHR user would result in significant hardship, such as in the case of an eligible hospital in rural area without sufficient internet access. An eligible hospital may not be granted an exemption for more than 5 years.</p> <p><i>Critical Access Hospitals</i> – Amends section 1814(1) of the Social Security Act to provide for fiscal year 2015 and each subsequent year, in the case of a critical access hospital that is not a meaningful EHR user for the reporting period for such fiscal year, the amount of payment under this part for inpatient critical access hospital services will be reduced to an amount equal to the following percentages of the reasonable costs of the critical access hospital in providing such services: 100.66 % for fiscal year 2015; 100.33 % for fiscal year</p>

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	<p>2016; and 100 % for fiscal year 2017 and each subsequent year. The hardship exception is applicable to critical access hospitals. Includes a restriction of administrative or judicial review of the methodology and standards for determining 1) the amount of payment and reasonable cost and payment adjustments, 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 section 1886(n)(2); 2) a 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; 3) the specification of EHR reporting periods under section 1886(n)(6)(B); 4) the identification of costs for purposes of paragraph (3)(C).</p> <p><i>Application to Certain MA-Affiliated Eligible Hospitals</i> – Amends section 1853 of the SSA to provide that a hospital that is under common governance with the MA organization and serves individuals enrolled under an MA plan offered by such organization shall be eligible for an incentive payment in the same manner as an eligible hospital that is not under such common corporate governance with a qualifying MA organization.</p> <p>Includes a posting on the CMS website, in an easily-understandable format, a list of names, business addresses, and business phone numbers of each qualifying MA organization receiving incentive payments under this subsection for eligible hospitals and a list of names of the eligible hospitals for which such incentive payment is based.</p> <p><i>Limitation on Review</i> – Restricts administrative or judicial review on the methodology and standards for determining 1) payment amounts and payment adjustments under this subsection, including avoiding duplication of payment; 2) eligible hospitals; 3) a meaningful EHR user.</p> <p>Implementation Funding</p> <p>In addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of HHS for the Centers for Medicare & Medicaid Services Program Management Account \$100,000,000 for each of the 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 part. Amounts appropriated under this subsection for a fiscal year shall be available until expended.</p> <p>Study on the Application of HIT Payment Incentives for Providers Not Receiving Other Incentive Payments</p> <p>The Secretary of HHS shall conduct a study to determine the extent to which and manner in which payment incentives and other funding for the purposes of implementing and using certified EHR technology should be made available to health care providers who are receiving minimal or no payment incentives or other funding under this Act, under title XVIII or XIX of the SSA, or otherwise, for such purposes. The study shall include an examination of the following:</p> <ol style="list-style-type: none"> 1) the adoption rates of certified EHR technology by such health care providers; 2) the clinical utility of such technology by such health care providers; 3) whether the services furnished by such health care providers are appropriate for or would benefit from the use of such technology; 4) the extent to which such health care providers work in settings that might otherwise receive an incentive payment or other

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	<p>funding under this Act, title XVIII or XIX of the SSA otherwise;</p> <p>5) the potential costs and the potential benefits of making incentives and funding available to such health care providers; and</p> <p>6) any other issues the Secretary deem to be appropriate.</p> <p>The Secretary shall submit the report to Congress not later than June 30, 2010 with the findings and conclusions of the study conducting under this subsection.</p> <p>[Secs. 4201, 4202, 4303]</p>
Medicaid Provider HIT Adoption and Operation Payments; Implementation Funding	<p><i>Funding EHR Technology Expenditures for Medicaid Providers</i> – Provides appropriations for 100% of payment to Medicaid providers to encourage the adoption and use of certified EHR technology. Provides appropriations for 90% of expenditures for reasonable administrative expenses related to payments for such technology.</p> <p>Identifies payments to encourage the adoption and use of certified EHR technology as payments made by the state:</p> <ul style="list-style-type: none"> • to Medicaid providers, as defined under A) below, not in excess of 85% of the net average allowable costs for such technology and the support services including maintenance and training that is for, or is necessary for the adoption and operation of, such technology; and • to Medicaid providers, as defined under B) below. <p>Defines “Medicaid provider” as A) a professional who is not hospital-based and has at least a 30% Medicaid patient volume, a professional who is a pediatrician who is not hospital-based, and who has at least 20% Medicaid patient volume, and a professional who practices predominantly in a federally qualified health center or rural health clinic that has at least a 30% Medicaid patient volume; and B) a children’s hospital or an acute-care hospital that has at least a 10% Medicaid patient volume. Allows Medicaid providers, as defined under this section, to include individuals enrolled in Medicaid managed care plans as a part of their Medicaid patient volume.</p> <p>Defines “certified EHR technology” as a qualified electronic health record (as defined under the PHSA) meeting standards adopted under that Act that are applicable to the type of record involved, as determined by the Secretary. Defines “eligible professional” as a physician, dentist, certified nurse mid-wife, nurse practitioner, and physician assistant. Defines “average allowable costs” as the average costs for the purchase and initial implementation or upgrade of certified EHR technology. Defines “hospital-based” with respect to an eligible professional (such as a pathologist, anesthesiologist, or emergency physician) who furnishes substantially all services in a hospital setting. Defines “net average allowable costs” as average allowable costs reduced by any payment made to a 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.</p> <p><i>Caps and Limitations on EHR Funding</i> – Limits net average allowable costs for certified EHR technology for the first year of payment (which may not be later than 2016) to not more than \$25,000. For costs for a subsequent year of payment, limits net average allowable costs to no more than \$10,000 for a period no longer than 5 years and not after 2021. For eligible pediatricians (as described above), limits dollar amounts to 2/3 of the amounts outlined in this subsection. Requires the Medicaid share of HIT amounts to be calculated in the same manner as the Medicare share under section 1886(n)(2)(D), as detailed. Requires the Secretary to ensure coordination of EHR</p>

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	<p>payment programs to assure no duplication of funding.</p> <p><i>Requirement on the State and the Medicaid Provider</i> – Conditions that 1) the reimbursement of payments for EHR technology by the state must be paid directly to the Medicaid provider without any deduction or rebate. Allows the state to make payments to an entity promoting the adoption of certified EHR technology, if participation in such a payment arrangement is voluntary for the eligible professional and if such entity does not retain more than 5% of such payments; 2) the provider is responsible for payment of the remaining 15% of the net average allowable cost; 3) the provider demonstrates, for the first year, that it is engaged in efforts to adopt, implement, or updated certified EHR technology, and for subsequent payment years, demonstrates meaningful use of certified EHR technology; and 4) the technology is compatible with state or federal administrative management systems. Further conditions a state’s participation by demonstrating to the Secretary that the state is 1) using the funds provided for the purpose of administering payments, including tracking of meaningful use by Medicaid providers; 2) conducting adequate oversight of the program, including routine tracking of meaningful use attestations and reporting mechanisms; and 3) pursuing initiatives to encourage the adoption of EHR technology to promote health care quality and the exchange of health care information.</p> <p>Requires the Secretary to periodically submit reports to Congress on the status, progress, and oversight of payments described in this section. Requires such reports to include the extent of adoption of certified EHR technology among Medicaid providers and any improvements in health outcomes, clinical quality, or efficiency resulting from such adoption.</p> <p>Allocates \$40,000,000 for each of the fiscal years 2009 through 2015 and \$20,000,000 for fiscal year 2016, to be available for purposes of carrying out the provisions of this part. Allows amounts appropriated for a fiscal year to be available until expended.</p> <p>[Sec. 4201]</p>
Relevant Privacy Definitions	<p>The term “breach” means the unauthorized acquisition, access, use, or disclosure of protected health information which compromises the security or privacy of such information, except when an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information. Does not include:</p> <ul style="list-style-type: none"> • any unintentional acquisition, access or use of such information by an employee or individual acting under the authority of a covered entity or business associate involved if: a) such acquisition, access, or use was made in good faith and within the course and the scope of the employment or other professional relationship of such employee or individual, respectively, with the covered entity or business associate; and b) such information is not further acquired, accessed, used, or disclosed by any person; or • any inadvertent disclosure from an individual who is otherwise authorized to access protected health information at a facility operated by a covered entity or business associate to another similarly situated individual at the same facility; and • any such information received as a result of such disclosure is not further acquired, accessed, used, or disclosed without authorization by any person. <p>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.</p> <p>The term “electronic health record” means an electronic record of health-related information on an individual that is created, gathered,</p>

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	<p>managed, and consulted by authorized health care clinicians and staff.</p> <p>The term “personal health record” means an electronic record of PHR identifiable health information on an individual that can be drawn from multiple sources and that is managed, shared, and controlled by or primarily for the individual.</p> <p>The term “PHR identifiable health information” means individually identifiable health information as defined in section 1171(6) of the SSA and includes, with respect to an individual, information:</p> <ul style="list-style-type: none"> • that is provided by or on behalf of the individual, and • that identifies the individual or with respect to which there is a reasonable basis to believe that the information could be used to identify the individual. <p>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 guidance issued by the Act. Should the Secretary not issue guidance by the date specified (which is 60 days after enactment), this term 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 that is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.</p> <p>The term “unsecured protected health information” means protected health information that is not secured through the use of a technology or methodology specified by the Secretary (relating to technologies and methodologies that render protected health information unusable, unreadable, or indecipherable).</p> <p>The terms “health care operations”¹, “covered entity,”² “business associate,”³ “disclose,”⁴ “health care provider,” “health plan,” “payment,” “protected health information,” “security,” “treatment,” and “use”⁵ are defined in title 45 of the Code of Federal Regulations (i.e., the HIPAA privacy and security regulations).</p>

¹ The term “health care operations” means any of the following activities of the covered entity to the extent that the activities are related to covered functions: (1) Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment; (2) Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities; (3) Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance), provided that the requirements of § 164.514(g) are met, if applicable; (4) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs; (5) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and (6) Business management and general administrative activities of the entity, including, but not limited to: (i) Management activities relating to implementation of and compliance with the requirements of this subchapter; (ii) Customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer. (iii) Resolution of internal grievances; (iv) The sale, transfer, merger, or consolidation of all or part of the covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and (v) Consistent with the applicable requirements of § 164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the covered entity.

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	[Secs. 4400/4407]
Application of Security Provisions and Penalties to Business Associates of Covered Entities; Annual Guidance on Security Provisions	Certain security provisions and penalties shall apply to business associates in the same manner as to covered entities. Each year, the Secretary will issue guidance on the latest safeguard technologies for use in carrying out the application of security provisions. [Sec. 13401]
Notification in the Case of Breach	Covered entities that access, maintain, retain, modify, record, store, destroy, or otherwise hold, use, or disclose unsecured protected health information are required to follow notification provisions that include: 1) notice to the individual; 2) notice to the media; and 3) notice to HHS. For notices to individuals, a covered entity shall notify each individual whose unsecured protected health information has been or is reasonably believed to have been accessed, acquired, or disclosed as the result of a breach. The bill specifies method and content requirements for notice to individuals. Business associates that maintain, retain, modify, record, store, destroy, or otherwise hold, use, or disclose unsecured protected health information shall notify the covered entity when a breach is discovered. Breaches shall be treated on the first day on which such breach is known or should reasonably have been known to have occurred. Notifications shall be made without reasonable delay and in no case later than 60 days after discovery. The covered entity or business associate bears the burden of demonstrating that all notifications were made in accordance with the requirements. If a law enforcement official determines that the required notification would impede upon a criminal investigation or threaten national security, notice to individuals may be delayed.

² The term “covered entity” means: (1) A health plan. (2) A health care clearinghouse. (3) A health care provider who transmits any health information in electronic form in connection with a transaction covered by this subchapter.

³ The term “business associate” means, with respect to a covered entity, a person who: (i) On behalf of such covered entity or of an organized health care arrangement (as defined in § 164.501 of this subchapter) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs, or assists in the performance of: (A) A function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or (B) Any other function or activity regulated by this subchapter; or (ii) Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in § 164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. (2) A covered entity participating in an organized health care arrangement that performs a function or activity as described by paragraph (1)(i) of this definition for or on behalf of such organized health care arrangement, or that provides a service as described in paragraph (1)(ii) of this definition to or for such organized health care arrangement, does not, simply through the performance of such function or activity or the provision of such service, become a business associate of other covered entities participating in such organized health care arrangement. (3) A covered entity may be a business associate of another covered entity.

⁴ The term “disclosure” means the release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information.

⁵ The term “use” means, with respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

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	<p>Notice to prominent media outlets is required following the discovery of a breach if the unsecured protected health information of more than 500 residents is or is reasonably believed to have been accessed, acquired, or disclosed. In addition, the HHS Secretary is to be notified immediately if the breach involves more than 500 individuals. For breaches involving less than 500 individuals, a covered entity can maintain a log and annually submit the log to the HHS Secretary. HHS will make publicly available a list of entities involved in breaches by posting this information on the Internet via the HHS website.</p> <p>No later than 12 months after enactment and annually thereafter, the Secretary shall submit to the Senate Finance and HELP Committees and to the House Ways & Means and Energy & Commerce Committees a report containing information regarding breaches for which the Secretary received notice. The Secretary shall promulgate interim final regulations no later than 180 days after enactment. Provisions apply to breaches that are discovered on or after the date that is 30 days after the publication of interim final regulations.</p> <p>[Sec. 13402]</p>
Education on Health Information Privacy	<p>No later than 6 months after enactment, the Secretary shall designate an individual in each regional HHS office to offer guidance and education to covered entities, business associates, and the public on their rights and responsibilities related to federal privacy requirements for protected health information.</p> <p>No later than 12 months after the date of enactment, the Office of Civil Rights within HHS shall develop and maintain a multi-faceted national education initiative to enhance public transparency regarding the uses of health information.</p> <p>[Sec. 13403]</p>
Application of Privacy Provisions and Penalties to Business Associates of Covered Entities	<p>Business associates that obtain or create protected health information on behalf of a covered entity can use or disclose the information only as specified by the business associate contract. The bill’s requirements relating to the additional privacy requirements must be included in business associate contracts. If a business associate knows about a covered entity’s activity or practice that would be a violation, then the business associate must either take steps to cure or end the violation. Otherwise, the business associate must terminate the contract or if termination is not feasible, report the problem to the Secretary of HHS. If a business associate violates these requirements, then the business associate can be subject to civil and criminal penalties for noncompliance.</p> <p>[Sec. 13404]</p>
Restrictions on Certain Disclosures and Sales of Health Information; Accounting of Certain Protected Health Information Disclosures;	<p><i>Self-Pay Provisions</i> – Should an individual request that a covered entity restrict the disclosure of his or her protected information, the covered entity must comply with the requested restriction if: 1) the disclosure is to a health plan for purposes of carrying out payment or health care operations (not treatment) (unless the disclosure is required by law); and 2) the protected health information pertains solely to a health care item or service for which the provider involved has been paid out-of-pocket in full.</p> <p><i>Minimum Necessary and Limited Data Set Requirements</i> – Covered entities are required to limit uses, disclosures, or requests of protected health information to the limited data set or, if needed by the entity, to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. The Secretary shall issue guidance on what constitutes “minimum necessary” no later than 18 months after enactment, taking into account guidance and the information necessary to improve patient outcomes and to detect, prevent, and manage chronic disease. Once the Secretary issues the guidance, the bill’s requirements relating to the limited data set and the minimum</p>

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Access to Certain Information in Electronic Format	<p>necessary rules will sunset. These provisions shall not be construed as affecting the use, disclosure, or request of protected health information that has been de-identified.</p> <p><i>Accounting for Disclosures</i> – If a covered entity uses or maintains an EHR, an individual shall have the right to receive an accounting of disclosures, including disclosures made for treatment, payment, and health care operations. The accounting should be for the 3 years preceding the date of request. The Secretary shall promulgate regulations no later than 6 months after adoption of standards about what information shall be collected about disclosures for treatment, payment, and health care operations made through an EHR. Such regulations shall only require such information to be collected through an EHR in a manner that takes into account the interests of individuals in learning the circumstances under which their information is being disclosed and the administrative burden of accounting for such disclosures. In response to a request for an accounting, a covered entity shall elect to provide either an: 1) accounting for disclosures of protected health information that are made by such entity and by a business associate acting on behalf of the entity, or 2) accounting 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. A business associate included on a list shall provide an accounting made by the business associate upon a request made by an individual directly to the business associate. These requirements will be effective on January 1, 2014 for entities that use EHRs as of January 1, 2009. In the case of covered entities who acquire EHRs after January 1, 2009, the effective date will be on and after the later of: 1) January 1, 2011, or 2) the date that the entity acquires an EHR. The Secretary may set an effective date that is later than the date specified if the Secretary determines necessary, though it may not be later than 2016 for users who acquired EHRs prior to January 1, 2009, or 2013 for users who acquired an EHR after that date.</p> <p><i>Sale of Protected Health Information</i> – 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 entity obtained a valid authorization from the individual which includes a specification of whether the protected health information can be further exchanged for remuneration by the entity receiving the information of that individual. Exceptions to this rule include if the purpose of the exchange is:</p> <ul style="list-style-type: none"> • for public health activities; • for research, and the price charged reflects the costs of preparation and transmittal of data for such purpose; • 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; • a specific health care operation relating to sales, transfers, mergers, and consolidations; • 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; • to provide an individual with a copy of the individual’s protected health information pursuant to section 164.5241 of title 45, Code of Federal Regulations (e.g., the right of individuals to access their health information maintained by the covered entity); • otherwise determined by the Secretary in regulations to be similarly necessary and appropriate. <p>The Secretary shall promulgate regulations to carry out these provisions no later than 18 months after enactment, and</p> <ul style="list-style-type: none"> • shall evaluate the impact of restricting the exception to require that the price charged reflects the costs of preparation and transmittal of data for such purpose, on research or public health activities, including those conducted by or for the use of the

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	<p>Food and Drug Administration; and</p> <ul style="list-style-type: none"> • may further restrict the exception to require that the price charged reflects the costs of the preparation and transmittal of data, if the Secretary finds that such further restriction will not impede such research and public health activities. <p>These regulations shall apply to exchanges occurring 6 months after the date of promulgation of final regulations.</p> <p><i>Access Rights</i> – If a covered entity maintains an EHR, an individual has the right to obtain a copy of his or her protected health 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 such choice is clear, concise, and specific; and any fee charged for such an electronic copy may not exceed the entity’s labor costs in responding to the request.</p> <p>[Sec. 13405]</p>
Conditions on Certain Contacts as Part of Health Care Operations	<p><i>Marketing</i> – A communication by a covered entity or business associate that is about a product or service and encourages recipients to purchase or use the product or service shall not be considered a health care operation unless the communication meets the requirements of 45 C.F.R. §164.501(1)(i, ii, or iii). [That section excludes from the definition of “marketing” any communication about a product or service that (i) describes a health-related product or service (or payment for such product or service) that is provided by, or included in a plan of benefits of, the covered entity making the communication and includes communications about: the entities participating in a health care provider network or health plan network, replacement of or enhancements to a health plan, and health-related products or services available only to a health plan enrollee that add value to, but are not part of, a plan of benefits; (ii) is for treatment of an individual; or (iii) is for case management or care coordination for the individual, or that directs or recommends alternative treatments, therapies, health care providers, or settings of care to the individual.] Any of these permitted communications shall not be considered a “health care operation” if the covered entity receives or has received direct or indirect payment in exchange for making the communication, except where:</p> <ul style="list-style-type: none"> • the communication describes only a drug or biologic that is currently being prescribed for the recipient of the communication, and any payment received by such covered entity in exchange for making a communication is reasonable in amount; • the communication is made by the covered entity, and the covered entity making such communication obtains a valid authorization from an individual; or • the communication is made by a business associate on behalf of the covered entity, and the communication is consistent with the written contract between such business associate and the covered entity. <p>The Secretary shall determine by regulation what constitutes reasonable amounts of any payment received by a covered entity in exchange for making a communication. “Direct or indirect payments” shall not include payments for treatment of an individual</p> <p><i>Fundraising</i> – The Secretary shall by rule provide that any written fundraising communication that is a “health care operation” 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 further communication, such election shall not be treated as a revocation of authorization under section 164.508 of title 45, Code of Federal Regulations.</p> <p>This section shall apply to written communications occurring on or after the date that is 12 months following enactment.</p>

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	[Sec. 13406]
Temporary Breach Notification Requirement for Vendors of Personal Health Records and Other Non-HIPAA Covered Entities	<p>Following discovery of a breach of unsecured PHR identifiable health information in records that are maintained or offered, each PHR vendor, as well as entities that are not covered entities or business associates, are required to notify: 1) each individual who is a U.S. citizen and whose unsecured PHR identifiable health information was acquired by an unauthorized person; and 2) the Federal Trade Commission (FTC). The bill requires the FTC to notify the Secretary of HHS in such situations. A third party service provider that provides services to a PHR vendor or other designated entities (including entities that offer products or services through the website of a vendor of personal health records and certain entities that are not covered by HIPAA) in connection with the offering or maintenance of a PHR or related product or service which accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses unsecured PHR individually-identifiable information shall, following discovery of a breach, notify such vendor or entity. The bill specifies timeliness, method, and content requirements that are the same as the requirements for covered entities (listed above).</p> <p>A violation shall be treated as an unfair and deceptive act or practice in violation of the FTC Act.</p> <p>The FTC is required to issue interim final regulations within 180 days of the bill’s enactment. The provisions apply to breaches of security that are discovered or are after the date that is 30 days after publication of interim final regulations.</p> <p>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, these provisions shall not apply to breaches of security discovered on or after the effective date of the regulations implementing such legislation.</p>
	[Sec. 13407]
Business Associate Contracts Required for Certain Entities	<p>Each organization that provides data transmission of protected health information to a covered entity or its business associate and that requires access on a routine basis to such information (e.g., Health Information Exchange Organization, a Regional Health Information Organization, an E-prescribing Gateway), or each vendor that contracts with a covered entity to allow the entity to offer a PHR to its patients as part of an EHR shall be treated as a business associate of the entity and is required to have a written contract in place.</p>
	[Sec. 13408]
Clarification of Application of Wrongful Disclosures Criminal Penalties	<p>Amends section 1177(a) of the SSA to clarify that a person (e.g., an employee or other individual) shall be considered to have obtained or disclosed individually identifiable health information in violation if the information is maintained by a covered entity and the individual obtained or disclosed such information without authorization. As such, the individual can be subject to criminal penalties.</p>
	[Sec. 13409]
Improved Enforcement	<p>The Secretary is required to impose penalties on violations due to willful neglect. The Secretary shall formally investigate any complaint of a violation if a preliminary investigation of the facts indicates such possible violation. The HHS Secretary shall promulgate regulations to implement this provision no later than 18 months after enactment. These provisions are applicable to penalties imposed on or after the date that is 24 months after enactment.</p> <p>Any civil monetary penalties or settlements collected shall be transferred to the HHS Office for Civil Rights to be used for enforcement</p>

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	<p>purposes. No later than 18 months after enactment, the Comptroller General shall recommend to the Secretary a methodology by which an individual who is harmed may receive a percentage of any civil monetary penalties or settlements. No later than 3 years after enactment, the Secretary shall establish a methodology to distribute a percentage of civil monetary penalties collected to harmed individuals.</p> <p>The bill creates a tiered increase in the amount of civil monetary penalties (the appropriate tier depends on whether an offense occurs and a person “did not know and by exercising reasonable diligence would not have known” about the violation, whether the offense is due to “reasonable cause,” or whether the offense is a result of “willful neglect”):</p> <ul style="list-style-type: none"> • \$100-\$25,000 • \$1,000-\$100,000 • \$10,000-\$250,000 • \$50,000-\$1,500,000 <p>The penalty structure will apply to violations occurring after the date of enactment of the bill.</p> <p>Authorizes state Attorneys General to enforce federal privacy and security laws. The state AGs can enjoin a violation or obtain damages on behalf of residents in a state in an amount equal to the number of violations multiplied by an amount up to \$100 (the total amount of damages imposed for all violations of an identical requirement or prohibition for a calendar year may not exceed \$25,000). Provisions relating to attorney’s fees, venue, notice to the Secretary, and concurring state/federal actions are detailed in the bill. Additional provisions require state AGs to notify the Secretary of HHS when initiating an action.</p> <p>Nothing in the enforcement provisions shall be construed as preventing OCR from continuing, in its discretion, the ability to use corrective action without a penalty if the person did not know, and by exercising reasonable diligence would not have known, about the violation.</p> <p>These provisions will apply to violations occurring after the date of enactment of the bill.</p> <p>[Sec. 13410]</p>
Audits	The Secretary shall provide for periodic audits to ensure compliance with privacy and security requirements. [Sec. 13411]
Relationship to Other Laws	The HIPAA preemption provisions apply in the same manner as they would for standards or transactions. For privacy and security of individually identifiable health information, the preemption provisions shall remain in effect to the extent that they are consistent with this subtitle’s provisions. The Secretary shall amend federal regulations to be consistent with these requirements. Nothing shall constitute a waiver of any privilege otherwise applicable to an individual with respect to the protected health information of the individual. [Sec. 13421]
Effective Date	Except as otherwise specified, Part I provisions take effect 12 months after enactment. [Sec. 13423]
Studies, Reports, Guidance	<i>Report on Compliance</i> – For the first year beginning after the date of enactment and annually thereafter, the Secretary shall prepare and submit to the Senate HELP Committee and House Ways & Means and Energy & Commerce Committees a report concerning complaints of alleged violations relating to privacy and security received by the Secretary during that year. This report shall include the number of complaints, how they were resolved, the number that have resulted in penalties, and the Secretary’s plan for improving compliance and

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	<p>enforcement for the following year, and for other information. Each report will be made available to the public on the HHS website.</p> <p><i>Study and Report on Application of Privacy and Security Requirements to Non-HIPAA Covered Entities</i> – No later than 1 year after enactment, the Secretary, in consultation with the FTC, shall conduct a study and submit a report to the Senate HELP, Finance, and Commerce Committees and to the House Ways & Means and Energy & Commerce Committees on privacy and security requirements for entities that are vendors of PHRs, entities that offer products or services through the website of a vendor of PHRs, entities that are not covered entities that offer products or services through the website of covered entities that offer PHRs, entities that are not covered entities but that access information in or send information to PHRs, and third party service providers that assist in offering PHRs.</p> <p><i>Guidance on Implementation Specification to De-Identify Protected Health Information</i> – No later than 12 months after enactment, the Secretary shall, in consultation with stakeholders, issue guidance on how best to implement requirements for the de-identification of protected health information.</p> <p><i>GAO Report on Treatment Disclosures</i> – No later than 1 year after enactment, the Comptroller General shall submit to the Senate HELP Committee and to the House Ways & Means and Energy & Commerce Committees a report on best practices related to disclosure among providers of protected health information for purposes of treatment. This report shall examine best practices implemented by states and other entities related to improving the quality of care provided to individuals, as well as the use of electronic informed consent for disclosing protected health information for treatment, payment, and health care operations.</p> <p><i>Report Required</i> – The Government Accountability Office shall submit to Congress and to the Secretary a report on the impact of any of the provisions of, or amendments made by, this division or division B that relate to HIPAA on health insurance premiums and overall health care costs. This report shall be submitted no later than 5 years after enactment.</p> <p><i>Study</i> – The Secretary shall study the definition of “psychotherapy notes” in section 164.501 of title 45, Code of Federal Regulations, with regard to including test data that is related to direct responses, scores, items, forms, protocols, manuals, or other materials that are part of a mental health evaluations, as determined by the mental health professional providing treatment or evaluation in such definitions and may, based on such study, issue regulations to revise such definition.</p> <p>[Sec. 13424]</p>
Temporary Increase of Medicaid FMAP	<p><i>Adjustments and Increases to FMAP</i> – Before the application of this section, allows the FMAP determined for fiscal year (FY) 2008 to be substituted for the state’s FMAP for FY 2009 if the state’s calculated FY 2009 rate is less than FY 2008. If the state’s calculated FY 2010 is less than the FY 2008 or FY 2009 rate, then the greater of FY 2008 or FY 2009 rate is substituted for FY 2010. If the state’s calculated rate for FY 2011 is less than the FY 2008, FY 2009 or FY 2010 rate, then the greatest fiscal year rate is substituted for the first calendar quarter for FY 2011. Increases the FMAP by 6.2 percentage points during the recession adjustment period (beginning on October 1, 2008 and ending on December 31, 2010). For a territory, the 6.2 percentage point increase shall only apply if the territory makes a one-time election to apply the increase in FMAP and a 15% increase, instead of a 30% increase under subsection (d).</p> <p><i>Increases to FMAP Weighted by the Level of Unemployment</i> – Increases the FMAP for a state by the number of percentage points equal to</p>

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	<p>the SMAP (the non-federal match for Medicaid after the hold harmless provisions plus 3.1% points are incorporated) multiplied by the <i>applicable percent</i> (as outlined below) as determined by the level of unemployment in a state.</p> <p>For the FMAP unemployment adjustment, requires a state to have satisfied any of the following:</p> <ul style="list-style-type: none"> A. An increase of at least 1.5 percentage points, but less than 2.5 percentage points, in the unemployment rate for the quarter. The <i>applicable percent</i> for this range of unemployment increase is 5.5%. B. An increase of at least 2.5 percentage points, but less than 3.5 percentage points in the unemployment rate for the quarter. The <i>applicable percent</i> for this range of unemployment increase is 8.5%. C. An increase of at least 3.5 percentage points in the unemployment rate for the quarter. The <i>applicable percent</i> for this range of unemployment increase is 11.5%. <p>Deems a state qualified for the FMAP unemployment adjustment, after it initially qualifies for such additional relief, for each subsequent calendar quarter ending before July 1, 2010.</p> <p>Maintains a state’s <i>applicable percent</i> FMAP unemployment adjustment through July 1, 2010, should the state’s percentage reduction for a calendar quarter be less than the percentage reduction applied for the preceding quarter. Requires the Secretary to notify a state at least 60 days prior to applying any lower percentage reduction to the state’s <i>applicable percent</i> FMAP unemployment adjustment.</p> <p>Defines “state unemployment increase percentage” for a state for a calendar quarter to be equal to the number of percentage points by which 1) the average monthly unemployment rate for the state for months in the most recent previous 3-consecutive-month period exceeds 2) the lowest average monthly unemployment rate for the state for any 3-consecutive-month period preceding the period described in 1) and beginning on or after January 1, 2006.</p> <p><i>Scope of and Exclusions from FMAP Increases</i> – Applies the increases in FMAP for a state under this section for purposes of Title XIX (Medicaid) of the Social Security Act (SSA). Precludes this section from applying to:</p> <ul style="list-style-type: none"> • Payments for disproportionate share hospital (DSH) payment adjustments in section 1923 of the SSA; • Payments under Title IV of the SSA (parts related to Temporary Assistance to Needy Families, child welfare services, and child support programs). Allows the increases under subsections (a) and (b) of this bill section to apply to payments under Part E of Title IV (related to Federal Payments for Foster Care and Adoption Assistance). For the purpose of the application of this section to the District of Columbia, payments under such part shall be deemed to be made on the basis of the FMAP applied with respect to such District for purpose of title XIX and the 6.2 percentage point adjustment; • Title XXI (SCHIP) of the SSA; or • Certain payments under Medicaid. <p><i>Conditions on the State to Receive FMAP Increases</i></p> <ul style="list-style-type: none"> • Prevents a state from receiving increases in FMAP if the eligibility standards, methodologies, or procedures under its state plan – including any waiver – are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan or waiver as in effect on July 1, 2008. Allows a state to reinstate eligibility standards, methodologies, or procedures that were

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	<p>in effect on July 1, 2008, in order to be eligible for increases in FMAP. Allows a state to be eligible for increases in FMAP until July 1, 2009, if a restriction to eligibility standards, methodologies, or procedures was applied after July 1, 2008, and before the enactment of this Act, if the state (prior to July 1, 2009) reinstates eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on July 1, 2008.</p> <ul style="list-style-type: none"> • Prohibits a state from depositing or crediting the increase in FMAP, directly or indirectly, into any reserve or rainy day fund. • Prohibits a state from receiving increases in FMAP (except for the increase in FMAP allowed under subsection (a) of this section) should the state require political subdivisions to pay a greater percentage of the non-federal share of expenditures under the state Medicaid plan for quarters during the recession adjustment period, than the percentage that would have been required by the state under such plan on September 30, 2008, prior to the application of this section. • Prohibits a state from receiving increases in FMAP if the state fails to pay promptly nursing facility and hospital claims in accordance with section 1902(a)(37)(A). Requires the state to report to the Secretary, on a quarterly basis, its compliance with this section (prompt pay requirements under Medicaid) as such requirements pertain to claims made for covered services during each month of the preceding quarter. <p>Requires each state that receives additional federal funds as a result of this section to submit a report to the Secretary, no later than September 30, 2011, in such form and manner as prescribed by the Secretary, regarding how the additional federal funds were expended.</p> <p>Sunsets the provisions of this section after the end of the rescission adjustment period.</p> <p>[Sec. 5001]</p>
Moratoria on Certain Medicaid Regulations	<p>Extends the moratoria established under (3) Section 7001(a)(3)(A) of the Supplemental Appropriations Act, 2008 (Public Law 110–252) on the following regulations from April 1, 2009, to July 1, 2009:</p> <ul style="list-style-type: none"> • Restricting reimbursement for school-based administrative and transportation services (72 FR 73635) • Limiting payments for targeted case management (72 FR 68077) • Limiting state use of certain provider taxes (72 FR 9685) <p>Adds to the moratoria by prohibiting the Secretary of HHS from taking any action (regulation, guidance, or other administrative action) to implement the final regulation relating to clarification of the definition of outpatient hospital facility services under the Medicaid program (73 FR 66187)</p> <p>Provides a Sense of Congress that the Secretary should not promulgate as final the following proposed regulations:</p> <ul style="list-style-type: none"> • Prohibiting Medicaid payments for GME (72 FR 2236) • Limiting payments to publicly owned hospitals and nursing homes (72 FR 29748) • Limiting payments for rehabilitation services (72 FR 45201) <p>[Sec. 5003]</p>
Extension of Transitional	<p>Requires a state Medicaid plan to offer transitional Medicaid assistance to families who become ineligible for aid due to increased hours of, or increased income from, employment, through December 31, 2010, by striking “September 30, 2003” and inserting “December 31,</p>

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Medical Assistance	<p>2010” in sections of the SSA. Amendment takes effect on July 1, 2009.</p> <p>Allows a state Medicaid plan to treat a reference to a 6-month period as a reference to a 12-month period, as outlined in Section 1925 of the SSA, allowing families that become ineligible for such aid, because of hours of, or income from, employment to continue eligibility for Medicaid for a 12-month period. Allows a state Medicaid plan to waive the requirement that a family must have received Medicaid assistance for at least 3 of the 6 months immediately preceding the month in which a family becomes ineligible for such aid because of hours of, or income from, employment, in order to be eligible for the 6-month (or 12-month) period of Medicaid coverage.</p> <p>Requires each state to collect and submit to the Secretary information on average monthly enrollment and average monthly participation rates for adults and children eligible for transitional Medicaid assistance, as well as the number and percentage of children who become ineligible for Medicaid under this extension of Medicaid eligibility whose medical assistance is continued under another eligibility category or who are enrolled under SCHIP. Requires an annual report to Congress with such information.</p> <p>Amendments take effect July 1, 2009.</p> <p>[Sec. 5004]</p>
Protections for Indians under Medicaid and CHIP	<p><i>Premiums and Cost Sharing Protection Under Medicaid</i> – Prohibits the imposition of an enrollment fee, premium, or similar charge, or a deduction, copayment, cost sharing, or similar charge against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services for which payment may be made under this title. In addition, prohibits the payment due under this title from being reduced by the amount of any enrollment fee, premium, or similar charge, or any deduction, copayment, cost sharing, or similar charge.</p> <p><i>Treatment of Certain Property from Resources for Medicaid and CHIP Eligibility</i> – Requires a state to disregard property (as listed in this section) from resources for purposes of determining the eligibility of an individual (who is an Indian) for Medicaid or CHIP. Continues current law protections of certain Indian property from Medicaid estate recovery.</p> <p><i>Rules Applicable Under Medicaid and CHIP to Managed Care Entities with Respect to Indian Enrollees and Indian Health Care Providers and Indian Managed Care Entities</i> – An Indian enrolled in a Medicaid managed care entity shall be allowed to choose an Indian health care provider as his or her primary care provider (PCP), if the entity has an Indian health care provider within its network. Conditions payments to a Medicaid managed care entity upon it satisfying the following requirements:</p> <ul style="list-style-type: none"> • Demonstrate that the number of Indian participating health care providers is sufficient to ensure timely access to covered Medicaid managed care services for those Indian enrollees who are eligible to receive services from such providers. • Agree to pay Indian providers, whether participating or nonparticipating providers in the entity, for covered services to eligible Indian enrollees, a rate equal to the rate negotiated between the entity and the provider involved, or if such a rate has not been negotiated, at a rate level to the rate paid to a participating non-Indian provider. • Agree to make prompt payment, consistent with Social Security Act section 1932(f), to Indian providers. • Agree to pay an Indian provider that is a federally qualified health center at the same rate of a non-Indian provider at a federally qualified health center. • Requires the state to pay an Indian provider that is not a federally qualified health center the difference between the amount a Medicaid managed care entity pays the provider for services rendered to an Indian enrollee and the rate that applies to the provision

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	<p>of such services under the state plan.</p> <p>Allows an Indian Medicaid managed care entity to restrict enrollment under such program to Indians and to members of specific Tribes in the same manner as Indian Health Programs may restrict the delivery of services to Indians. Defines “Indian health care provider” as an Indian Health Program or an Urban Indian Organization. Defines “Indian Medicaid managed care entity” as an entity that is controlled the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organizations. Applies these new provisions to the state’s CHIP program.</p> <p><i>Consultation on Medicaid, CHIP, and Other Health Care Programs Funded Under the SSA Involving Indian Health Programs and Urban Indian Organizations</i> – Requires the Secretary to maintain within CMS a Tribal Technical Advisory Group, which was first established in accordance with requirements dated September 30, 2003. Requires the Secretary to include a representative from the Urban Indian Organization and the Service. Requires a state, in which 1 or more Indian Health Programs or Urban Indian Organizations furnishes health care services, to provide a process where the state seeks advice on a regular and ongoing basis from designees of such Indian Health Programs or Urban Indian Organizations on matters that are likely to have a direct effect on Indian Health Programs or Urban Indian Organizations. Requires such a state to solicit advice from designees prior to submission of any plan amendments, waiver request, and proposals for demonstrations projects likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations. Allows a state to include the appointment of an advisory committee and of a designee of such Indian Health Programs or Urban Indian Organizations to the medical care advisory committee advising the state on its state plan. Applies this new provision to the state’s CHIP program. Nothing in these amendments shall be construed as superseding existing advisory committees, working groups, guidance or other advisory procedures established by the Secretary or by any state with respect to the provision of health care to Indians.</p> <p>Amendments made by this section shall take effect July 1, 2009.</p> <p>[Sec. 5006]</p>
Temporary Increase in DSH Allotments During Recession	<p>Adjusts the DSH allotment for fiscal year 2009 to 102.5% of the amount determined for fiscal year 2009 without the application of this section. Adjusts the DSH allotment for fiscal year 2010 to 102.5%, in the same manner as described above. Prevents these provisions from application in the case that the DSH allotment for a state would grow higher than the DSH allotment under this section. [Sec. 5002]</p>
Comparative Effectiveness Research	<p>The bill appropriates \$700,000,000 to the Agency for Healthcare Research and Quality (AHRQ) for comparative effectiveness research (CER), provided that \$400,000,000 from that amount is transferred to the Office of the Director of the National Institutes of Health (NIH) to conduct or support such research. Money delegated to the Office may be transferred to national research institutes and to the Common Fund established under section 402A(c)(1) of the PHSA.</p> <p>In addition, \$400,000,000 shall be available for comparative clinical effectiveness research and allocated at the discretion of the Secretary, provided that the funds are used to accelerate the development and dissemination of comparative effectiveness research through efforts that: 1) conduct, support, or synthesize research comparing clinical outcomes, effectiveness, and appropriateness of items, services, and procedures used to prevent, diagnose, or treat diseases, disorders, and other health conditions; and 2) encourage the development and use of clinical registries, clinical data networks, and other forms of electronic health data that can be used to generate or obtain outcomes data.</p>

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	<p>The Secretary shall contract with the Institute of Medicine (IOM) to produce and submit a report to Congress by June 30, 2009 on recommendations on national priorities for comparative clinical effectiveness research; no more than \$1,500,000 shall be made available from the appropriated funds for this initiative. The Secretary shall consider any recommendations of the Federal Coordinating Council for Comparative Effectiveness Research (see below for description) and the IOM in designating activities to receive funds, and may make grants and contracts with appropriate entities (such as HHS and other government entities, as well as private entities) that have demonstrated experience and capacity to achieve the goals of comparative effectiveness research. The Secretary shall publish information on grants and contracts awarded within a reasonable time, and shall disseminate findings to clinicians, patients and to the general public as appropriate. To the extent practicable, recipients of the funds should offer the opportunity for public comments on the research. Research conducted with appropriated funds shall be consistent with Departmental policies relating to the inclusion of women and minorities in research.</p> <p>The Secretary shall provide the House and Senate Appropriations Committees, the House Energy & Commerce and Ways & Means Committees, and the Senate HELP and Finance Committees with an annual report on research conducted or supported through the funds. The Secretary, jointly with the Directors of AHRQ and NIH, is required to provide the Committees on Appropriations of the House of Representatives and the Senate a fiscal year 2009 operating plan for the funds appropriated under this heading before making any federal Obligations of such funds in fiscal year 2009, but not later than July 30, 2009, and a fiscal year 2010 operating plan for such funds before making any Federal obligations of such funds in fiscal year 2010, but not later than November 1, 2009. This report should include the type of research being conducted or supported, including the priority conditions addressed, specifications on the allocation of resources within the Department of Health and Human Services. The Secretary, jointly with the aforementioned, are required to provide the Committee on Appropriations of the House and the Senate a report on actual obligations, expenditures, and unobligated balances for each activity funded in this section no later than November 1, 2009 and every 6 months thereafter as long as funding provided in this section is available for obligation or expenditure.</p> <p>[Title VIII]</p> <p><i>Federal Coordinating Council for Comparative Effectiveness Research</i> – Established in the bill, the Council shall assist the offices and agencies of the federal government (including Departments of HHS, Veterans Affairs, and Defense, as well as other departments or agencies) to coordinate the conduct or support of comparative effectiveness research; and advise the President and Congress on strategies with respect to infrastructure needs of comparative effectiveness research within the federal government, and appropriate organizational expenditures. The Council shall be composed of no more than 15 members, and shall include 1 senior officer/employee from AHRQ, CMS, NIH, ONCHIT, FDA, Veterans Health Administration, and the office within the Department of Defense responsible for management of the Military Health System. At least half of Council’s members should be physicians or other experts. No later than June 30, 2009, the Council shall submit to the President and Congress a report describing federal activities on comparative effectiveness research and recommendations for additional investments. Annually, the Council shall submit to Congress a report on activities and recommendations concerning infrastructure needs, organization expenditures, and opportunities for better coordination. Includes a provision that nothing in this section shall be construed to permit the Council to mandate coverage, reimbursement, or other policies for any public or private payer. Similarly, none of the reports submitted under this section or recommendations made by the Council shall be construed as mandates or clinical guidelines for payment, coverage, or treatment.</p>

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	In the Senate Appropriations Committee Report of the bill, declares the committee’s intention that this appropriation “supports the development of research on the relative <i>effectiveness</i> of different health care services and treatment options” and that the additional funding is for “comparative effectiveness research.” (emphasis added) The report does not mention the committee’s intention that this funding be used to gauge the cost effectiveness of services and treatment options.
Repeal of Withholding Tax on Government Contractors	Delays the provision for 1 year so that the withholding will begin for payments made after January 1, 2012. [Sec. 1511]



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