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Congress of the United States

U.S. House of Representatives

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June 13, 2006

To: Members, Committee on Ways and Means

Fr: Bill Thomas, Chairman

Re: Health Subcommittee Report

The Subcommittee on Health marked up H.R. 4157, the "Health Information Technology Promotion Act of 2005," on May 24, 2006. H.R. 4157 was ordered favorably reported to the Full Committee, as amended, by a roll call vote of 8-5.

Pursuant to Committee Rule 11, Subcommittee Chairman Johnson submitted a Subcommittee Report to the Full Committee on Tuesday, June 13, 2006. Attached is a copy of the Subcommittee Report.

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Congress of the United States
U.S. House of Representatives
COMMITTEE ON WAYS AND MEANS
WASHINGTON, DC 20515
SUBCOMMITTEE ON HEALTH

June 13, 2006

The Honorable William Thomas
Chairman, Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Chairman,

On May 24, 2006, the Subcommittee on Health ordered favorably reported to the Full Committee, H.R. 4157, the "Health Information Technology Promotion Act of 2005," as amended, by a vote of 8-5.

The Subcommittee proposal would improve the safety and quality of health care for Americans, while reducing costs.

Transmitted herein, in accordance with Committee Rule 11, is a report containing a comparison with present law, a section-by-section analysis of the proposed changes, and a section-by-section justification.

Sincerely,



Nancy Johnson
Chairman

2006 JUN 13 10 41 AM
U.S. HOUSE OF REPRESENTATIVES
CLERK OF THE HOUSE

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I. INTRODUCTION

**Committee on Ways and Means
Subcommittee on Health
Subcommittee Report on H.R. 4157
The “Health Information Technology Promotion Act of 2006”**

A. PURPOSE

Broad use of information technology throughout the health care delivery system is essential to improve the quality and efficiency of health care delivery. The adoption of health information technology is increasingly necessary to deliver state of the art care to individuals with chronic illness to promote interoperability between private and public providers and payers. Efficiencies gained by the coordinated development of health information technology will accelerate and advance private and public efforts to improve quality of care and reduce health costs.

The purpose of the Health Information Technology Promotion Act of 2006 (H.R. 4157) is to create the Office of the National Coordinator for Health Information Technology to accelerate and oversee the development of interoperability efforts in the public and private health care sectors and to coordinate Federal government activities relating to health information technology (IT). The bill would enable private sources of funding to finance physician adoption of health IT by providing exceptions and safe harbors in the fraud and abuse laws, and would provide for a study of state and federal security and confidentiality laws and regulations to assure the protection of patient health information as we move to electronic systems. In addition, the bill would direct the Secretary to modernize the coding system, develop procedures to ensure timely updating of standards that enable electronic exchanges, and provide a report on the work conducted by the American Health Information Community and its role in the future. Finally, the bill would direct the Secretary to develop a strategic plan for coordinating implementation of health IT. It is intended that these provisions would coordinate, advance and speed the development and use of health IT with the goals of improving the quality of care delivered, reducing fraud and abuse and health care costs, and promoting the coordination of care to promote better health outcomes.

B. SUMMARY

Office of the National Coordinator for Health Information Technology.—This bill would codify the Office of the National Coordinator for Health IT (ONCHIT) in statute and clearly delineate its ongoing roles and responsibilities. The duties of the office would include: maintaining and updating the strategic plan to guide the nationwide implementation of interoperable health IT to improve health care quality, reduce medical errors, increase the efficiency of care, and advance the delivery of appropriate evidence-based health care services; and serving as the principal advisor to the Secretary of Health and Human Services (HHS) on the use of health IT.

Duties of this office would also include serving as the coordinator of Federal government activities related to the development and maintenance of standards used in health information

exchange and the certification and inspection of health IT products to ensure that such products conform to the standards noted above. Also, duties would include coordinating health IT policies and programs across Federal agencies and providing input and advice to the Office of Management and Budget regarding Federal health IT programs.

Stark/Anti-Kickback Safe Harbors.—This bill would include statutory exceptions and safe harbors in physician self-referral (“Stark” laws) and anti-kickback laws that would allow hospitals, groups practices, and other entities to provide physicians with hardware, software, or IT training and support services that are used for the electronic exchange of health information.

Further, donors of such technology may not impose conditions limiting its use by physicians to individuals who are also patients of the donor entity; nor can donors limit physicians’ use of the technology in conjunction with other IT systems that physicians might utilize or condition donations based on the volume or value of referrals or business generated by the physician. This bill would also require written agreements regarding the remuneration, and would allow this exception to preempt state laws governing self-referral and anti-kickback to ensure that the federal exception can be implemented. Any gift must be for the purpose of better coordination of care, to improve quality or improve efficiency.

Privacy/Security Standards. — This bill would require the Secretary of HHS to conduct a study of the various state privacy laws and security standards, and how those laws would affect the electronic exchange of health information.

The study would examine the degree to which the laws vary or are consistent among states and between states and current Federal standards. The study would also examine the extent to which such variation adversely impacts the security and confidentiality of individually identifiable health information, and the reliability of interoperable systems.

The bill would require the Secretary to report back to Congress within 18 months with determinations on whether state and federal security and confidentiality laws need to be made more consistent to strengthen the security and confidentiality of individually identifiable health information, and, if so, how such laws and standards should be conformed.

If Congress does not enact legislation 18 months after receipt of the study, the Secretary has the authority, but is not required, to modify federal security and confidentiality standards and limit State security and confidentiality laws.

Adoption of Modern Coding System.—This bill would require the Secretary to adopt the updated Health Insurance Portability and Accountability Act (HIPAA) transaction standard ASC X12 5010 (to replace ASC X12 4010) for transactions occurring on or after April 1, 2009. The standard applies to claims transactions.

This bill would also require the Secretary to adopt the updated National Council for Prescription Drug Programs (NCPDP) standard version D.0 for transactions occurring on or after April 1, 2009. The Secretary is also required to adopt, per the past recommendation of the National Committee on Vital Health Statistics (NCVHS), the ICD-10 coding system by for transactions

occurring on or after October 1, 2009. The standard applies to coding for diagnosis and procedures.

Procedures to Ensure Timely Updating of Standards.—This bill would adopt an accelerated process for updating standards in order to keep pace with the development of technology. The Secretary is required to publish a notice in the Federal Register and receive and consider comments on proposed additions or modifications developed by a HIPAA standard setting organization that is proposed to the NCVHS and the Designated Standard Maintenance Organization (DSMO). The NCVHS would then submit its recommendation to the Secretary within 90 days. The Secretary would either adopt or reject proposed modifications or additions to existing standards within 90 days if the NCVHS recommends the change.

Report on the American Health Information Community.—This bill would require the Secretary of HHS to report back in one year on the activities of the American Health Information Community (AHIC), with recommendations for the ongoing structure and responsibilities of the entity.

AHIC was formed to provide input and recommendations to HHS on how to make health records digital and interoperable, and assure that the privacy and security of those records are protected.

Strategic Plan for Coordinating Implementation of Health Information Technology.—This bill would require the Secretary to develop a strategic plan to coordinate implementation efforts for health IT standards, HIPAA transaction standards, and new coding systems. This plan will address how activities would be coordinated between the Office of the National Coordinator for Health IT, the American Health Information Community, the Office of Electronic Standards and Security, and the National Committee for Vital Health Statistics.

Promotion of Telehealth Services.—This bill would require the Secretary to encourage and facilitate the adoption of State licensure agreements in order to provide telehealth services across state lines. The Secretary would also be required to study the use of store and forward technology in the provision of telehealth services under the Medicare program and the expansion of telehealth services in home health agencies and county mental health clinics or other publicly funded mental health facilities.

C. SUBCOMMITTEE ACTION

During the 108th and 109th Congresses, the Subcommittee held a series of four hearings on health care information technology: June 17, 2004; July 22, 2004; July 27, 2005; and April 6, 2006. Subcommittee Chairman Nancy Johnson and Energy and Commerce Health Subcommittee Chairman Deal introduced the “Health Information Technology Promotion Act of 2005” (HR 4157) on October 27, 2005. The bill has been referred to the Committee on Ways and Means, and to the Committee on Energy and Commerce, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

On June 17, 2004, the Ways and Means Subcommittee on Health held its first hearing on health

care information technology and heard testimony from the National Health Information Technology Coordinator Dr. David Brailer and Dr. Robert Kolodner, Acting Chief Health Informatics Officer, Department of Veterans Affairs. A second panel consisted of Dr. Charles Safran, American Medical Informatics Association; Janet Marchibroda, eHealth Initiative; Dr. Marc Overhage, Indiana University; and Dr. Andrew Wiesenthal, Kaiser Permanente.

The Subcommittee on Health held its second hearing on July 22, 2004, on electronic prescribing and heard testimony from Dave McLean, RxHub; Craig Fuller, National Association of Chain Drug Stores; Dr. Thomas Sullivan, Women's Health Center Cardiology; and Dr. Jonathan Teich, Harvard University.

The Subcommittee on Health held its third hearing on July 27, 2005, on health care information technology and heard testimony from the National Health Information Technology Coordinator, Dr. David Brailer. A second panel consisted of Dr. Don Detmer, American Medical Informatics Association; Linda Kloss, American Health Information Management Association; Dr. Allen Weiss, Naples Community Hospital Healthcare System; Joy Pritts, Health Policy Institute; and Mary Grealy, Healthcare Leadership Council.

The Subcommittee on Health held its final hearing in a series of four hearings on April 6, 2006, and heard testimony from the National Health Information Technology Coordinator, Dr. David Brailer; Lewis Morris, Inspector General, Department of HHS; and Dr. Simon Cohn, National Committee on Vital and Health Statistics. The second panel consisted of Brent Henry, Partners HealthCare System; Dr. Kenneth Kizer, Medsphere Systems Corporation; Joseph Smith, Arkansas Blue Cross Blue Shield; and Glorianne Bryant, Catholic Healthcare West.

II. EXPLANATION OF PROVISION

Section 1. Short Title and Table of Contents

Current Law.

No provision.

Explanation of Provision.

The provision specifies the title of the Act as the Health Information Technology Promotion Act of 2006. The provision also includes a brief table of contents, which lists the Act's eight sections.

Effective Date.

No provision.

Section 2. Office of the National Coordinator for Health Information Technology.

Current Law.

There are no existing statutory provisions regarding the Office of the National Coordinator for Health Information Technology (ONCHIT). The current ONCHIT was created by Executive Order 13335, signed by President Bush on April 27, 2004, which required the Secretary of HHS to establish within the Office of the Secretary an Office of the National Coordinator for Health Information Technology. The National Coordinator was instructed to develop, maintain, and direct a strategic plan to guide the nationwide implementation of interoperable health IT in the public and private health care sectors. The National Coordinator was also required, within 90 days, to report to the Secretary on progress towards the strategic plan. On July 21, 2004, the National Coordinator delivered that report, titled *Strategic Framework: The Decade of Health Information Technology: Delivering Consumer-centric and Information-rich Health Care*.

On October 6, 2005, ONCHIT awarded: (1) a \$3.3 million contract to the American National Standards Institute to convene a panel of standards development organizations to develop a harmonization process for achieving a widely accepted and useful set of interoperable health IT standards; and (2) a \$2.7 million contract to the Certification Commission for Health Information Technology, a nonprofit organization created by three health industry associations, to develop a process for certifying electronic health records and the network components through which they interoperate.

Explanation of Provision.

The bill would establish within HHS an Office of the National Coordinator for Health Information Technology. The National Coordinator would be appointed by the President and report directly to the Secretary. The National Coordinator would be required to perform duties consistent with the development of a nationwide interoperable health IT infrastructure that, among other things, improves health care quality, promotes wellness, reduces health care costs, improves health information exchange, and ensures health information privacy and security. Those duties would include: (1) directing and overseeing the continuous improvement of a strategic plan to guide implementation of a nationwide interoperable health IT infrastructure; (2) acting as the principal advisor to the Secretary on health IT and coordinating all health IT programs within the department; (3) coordinating health IT activities across the federal government and, using private entities to the maximum extent possible, providing for the development of health IT standards and the certification of health IT products; and (4) advising the Director of the Office of Management and Budget on Federal health IT programs.

The bill would authorize, for each of FY2006 through FY2010, such sums as may be necessary to carry out the activities of ONCHIT. Further, the bill would nullify Executive Order 13335. Finally, the bill would provide for the transfer of all functions, personnel, assets, liabilities, administrative actions, and statutory reporting requirements applicable to the existing ONCHIT to the new ONCHIT created under the Act.

Reasons for Change.

No statutory position currently exists to coordinate health information technology initiatives for the Federal Government. The current Office of the National Coordinator for Health Information Technology was created by executive order. Congress should create a

statutory position to ensure ongoing attention to health IT issues. This provision would codify the existing Office of the National Coordinator and specify its role in coordinating public/private partnerships to develop technology standards without creating a new government infrastructure to address the issue.

Effective Date.

Upon enactment.

Section 3. Safe Harbors for the Provision of Health Information Technology and Services to Health Care Professionals.

Current Law.

The Federal anti-kickback statute (42 USC 1320a-7b(b)) prohibits an individual or entity from knowingly or willfully offering or accepting remuneration of any kind to induce a patient referral for, or purchase of, an item or service covered by any Federal health care program. Violations of the law are punishable by up to five years in prison, criminal fines up to \$25,000, administrative civil money penalties up to \$50,000, and exclusion from participation in federal health care programs. HHS issues regulations designating specific safe harbors for various payment and business practices that would otherwise be implicated by the anti-kickback statute and subject to its criminal and civil prosecution.

The Medicare physician self-referral law (42 USC 1395nn(e)) prohibits physicians from referring patients to any entity for certain health services if the physician has a financial relationship with the entity, and prohibits entities from billing for any services resulting from such referrals, unless an exception applies. On March 25, 2004, CMS issued an interim final rule creating several new Stark exceptions, including one for health IT items and services furnished by an entity to physicians to enable them to participate in “community-wide health information systems.”

The Medicare Modernization Act (P.L. 108-173, Section 101) instructed the Secretary to establish a safe harbor from penalties under the anti-kickback statute and an exception to the Stark law for the provision of health IT and training services used in electronic prescribing. That would allow, for example, a hospital to provide such technologies and services to its medical staff, and Medicare Advantage plans to provide such technologies and services to pharmacies and prescribing health care providers. Proposed regulations were issued on October 5, 2005. While the proposed safe harbor covers health IT used solely for e-prescribing, as instructed by MMA, the proposed Stark exception would apply more broadly to health IT for electronic health records, provided they include electronic prescribing as one component.

Explanation of Provision.

The bill would create a safe harbor from civil monetary penalties under the anti-kickback statute for health IT and related services provided by a hospital or critical access hospital to a physician, subject to several requirements. The provision of health IT and related services must be made pursuant to a written agreement specifying the goal of improved health care quality, and coordination of care, and it must be made without a condition that: (1) limits or restricts their use to services provided by the physician to individuals receiving services at the location of the hospital or critical access hospital; (2) limits or restricts their use in conjunction with other health IT; or (3) takes into account the volume or value of referrals (or other business generated) by the physician to

the hospital or critical access hospital. In addition, the bill would create a safe harbor from criminal penalties under the anti-kickback statute for health IT and related services solicited or received by a person, subject to the same requirements. Finally, the bill would create an exception to the Stark law for health IT and related services provided by an entity to a physician, again subject to the same requirements.

For the purposes of this section, health IT includes hardware, software, license, intellectual property, equipment, or other IT used primarily for the electronic creation, maintenance, and exchange of health information.

The bill would require the Secretary, within 180 days of enactment, to promulgate implementing regulations. It also would preempt state laws that would otherwise penalize the provision of health IT and related services as described in this section. In addition, the bill would instruct the Secretary, within three years of enactment, to report to Congress on the impact of each of the safe harbors and the Stark exception on increasing health IT adoption and on the business relationships between providers. The Secretary would be required to include in the report recommendations for changes in the safe harbors and Stark exception, as may be appropriate.

Reasons for Change.

Currently, all donations of health information technology are subject to the restrictions imposed under the fraud and abuse laws. The penalties for remuneration in the form of health information technology in violation of such laws are severe and include potential exclusion from Federal programs. Current law has precluded the broad diffusion of health information technology that would improve care coordination, and the quality and efficiency of health care services. Accordingly, Congress needs to provide clear and broad exceptions to current law. This provision would enable health care providers and other entities to donate health information technology without fear of violation, which would promote more widespread diffusion of health information technology.

Effective Date.

The amendments made by this section to the anti-kickback statute and the Stark law would take effect 180 days after enactment.

Section 4. Consistency and Variation in Health Information Laws and Regulations.

Current Law.

Under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA, P.L. 104-191, 42 USC 1320d), Congress set itself a three-year deadline to enact health information privacy legislation. If, as turned out to be the case, the Congress was unable to enact such legislation before the deadline, the Secretary was instructed to promulgate regulations containing standards to protect the privacy of individually identifiable health information. Under the HIPAA privacy rule (45 CFR Parts 160, 164), which became effective for health care providers and most health plans in April 2003, all applicable state and Federal laws must be complied with unless it is impossible to comply with both and if the state law is less protective of medical privacy.

HIPAA also instructed the Secretary to develop security standards to safeguard electronic patient information against unauthorized access, use, and disclosure. The security standards (45 CFR Parts 160, 162, 164), which became effective for health care providers and most health plans in April 2005, preempt contrary state laws, except for exception determinations made by the Secretary. On October 6, 2005, ONCHIT awarded an \$11.5 million contract to RTI International in association with the National Governors Association to assess variations in business policies and state laws that affect privacy and security practices that may pose challenges to the secure electronic exchange of health information, and identify practical solutions for addressing such variation. State solutions and implementation plans are expected to be finalized in early 2007.

Explanation of Provision.

The bill would require the Secretary to study variation in State and Federal (HIPAA) health information privacy and security requirements and how such variation may adversely impact the security and confidentiality of patient information and the electronic exchange of such information. The Secretary would have to report to Congress, within 18 months, on whether and how such requirements should be made more consistent to better protect or strengthen the privacy and security of individually identifiable health information that is electronically exchanged.

The bill would give Congress 18 months following receipt of the Secretary's report to enact legislation to implement the report's recommendations; including modifying the HIPAA privacy and security standards and limiting the application of state privacy and security laws. If Congress failed to act within that period, the Secretary could, by rule, modify the HIPAA privacy and security standards and/or limit the application of state privacy and security laws based upon the report's recommendations.

Reasons for Change.

There are currently numerous, and conflicting, State and Federal laws and regulations to protect the security and confidentiality of patient information. The lack of consistency makes compliance with laws difficult and limits the ability for patient information to be appropriately shared to ensure the best patient care. Congress needs additional information to determine whether consistency among federal standards and state laws is necessary. This provision would require the Secretary of HHS to conduct a study of the State and Federal laws and regulations governing health information exchange and to assess the strengths and weaknesses of those laws and regulations. This study will provide an important opportunity for all interested parties to debate the issues of security and confidentiality that arise when discussing health IT, without mandating any future change to the existing regulatory framework.

Effective Date.

Upon enactment.

Section 5. Implementing Modern Coding System; Application Under Part A of the Medicare Program.

Current Law.

To support the growth of electronic record keeping and claims processing in the nation's health care system, HIPAA's Administrative Simplification provisions instructed the Secretary to adopt

electronic format and data standards for several routine administrative transactions between health plans and health care providers (e.g., claims for payment). The Secretary was to rely on the recommendations of the National Committee on Vital and Health Statistics (NCVHS), consult with appropriate federal and state agencies and private organizations, and publish in the Federal Register any NCVHS recommendation regarding the adoption of a standard. Final standards for eight electronic transactions and for code sets to be used in those transactions (45 CFR Parts 160, 162) were issued in August 2000. The transactions standards include several Accredited Standards Committee X12 (ASC X12) version 4010 standards, and the National Council for Prescription Drug Programs (NCPDP) Telecommunications Standard version 5.1. The code sets adopted by the Secretary include the International Statistical Classification of Diseases and Related Health Problems, 9th revision, Clinical Modification (ICD-9-CM).

HIPAA also instructed the Secretary to review and, not more frequently than once a year, modify the Administrative Simplification standards. Again, the Secretary was to rely on the recommendations of the NCVHS and publish in the Federal Register any NCVHS recommendation regarding the modification of a standard. Any such modification must be completed in a manner that minimizes disruption and the cost of compliance. Regarding code sets (e.g., ICD codes), any modification must also include instructions for the conversion or translation of prior encoded data elements so as to preserve the informational value of the data.

Explanation of Provision.

The bill would require the Secretary, not later than April 1, 2007, to promulgate a final rule to provide for the following modification of the HIPAA Administrative Simplification standards: (1) replacement of the ASC X12 version 4010 standards with version 5010; (2) replacement of the NCPDP Telecommunications Standard version 5.1 with version D.0; and (3) replacement of the ICD-9-CM with both the ICD-10-CM and ICD-10-PCS (Procedure Coding System). The Secretary would be required, within 30 days of enactment, to publish a Federal Register notice of the requirement to issue such a final rule. The final rule would not be subject to judicial review. The new ASC X12 and NCPDP standards would apply to electronic administrative transactions occurring on or after April 1, 2009. The new ICD codes would apply to electronic administrative transactions occurring on or after October 1, 2009. The upgraded ASC standards and ICD-10 codes also would apply to electronic payment transactions under Medicare Part A.

Reasons for Change.

The current system for coding health information was developed in the 1970s and it is outdated, inaccurate and running out of codes. A more modern coding system exists and has been adopted by virtually all other first world nations. The new coding system allows providers to more accurately code diagnosis and procedures used in treating patients to ensure better health outcomes, increased efficiency, and higher quality. Updating the coding system is important to realizing the full benefits of health IT. HHS has full authority to require the move to an updated coding system, and this change has been recommended by the National Committee for Vital Health Statistics, but to date HHS has not acted.

Effective Date.

Upon enactment.

Section 6. Procedures to Ensure Timely Updating of Standards that Enable Electronic Exchanges.

Current Law.

As previously noted, HIPAA instructed the Secretary to review and, not more frequently than once a year, modify the Administrative Simplification standards. Any such modification must be completed in a manner that minimizes disruption and the cost of compliance. Regarding code sets (e.g., ICD codes), any modification must also include instructions for the conversion or translation of prior encoded data elements so as to preserve the informational value of the data.

Explanation of Provision.

The bill would amend HIPAA's Administrative Simplification provisions to help expedite the adoption of additions and modifications to the electronic transactions standards. The Secretary would be required to publish a Federal Register notice within 30 days of receiving a notice from a standard setting organization that: (1) it is initiating the process of developing an addition or modification to an existing standard; (2) has prepared a preliminary draft of an addition or modification to an existing standard; or (3) has a proposed addition or modification that it intends to submit for review and consideration. In each instance, the published notice would provide the opportunity for public participation and comment. In the case of a proposed addition or modification, the bill would require the standard setting organization, having responded to public comment, to submit its proposal to both the Designated Standard Maintenance Organization (DSMO) and the NCVHS. The DSMO reviews the request with its constituent members (i.e. X12, NCPDP, HL7, NUBC, NUCC, and DeCC) concurrent to review by the NCVHS. The NCVHS would be required within 90 days to conduct a public hearing and submit its recommendation for adopting or rejecting the proposed addition or modification to the Secretary. The Secretary would then have 90 days to accept or reject the recommendation, and a further 30 days to publish a notice of such determination in the Federal Register. If the determination is to accept the NCVHS recommendation, the notice would include the modified standard as a final rule. The final rule would not be subject to judicial review.

Reason for Change.

The current HIPAA Federal process to adopt updated or modified versions of transaction standards is slow, sometimes taking months or even years. The current process does not allow for the quick implementation of updated versions for HIPAA transactions that have already been adopted. This provision would allow for a more streamlined process to update or modify transaction standards, so as these standards continue to evolve over time, the Federal process does not lag behind.

Enactment Date.

Upon enactment.

Section 7. Report on the American Health Information Community.

Current Law.

On July 14, 2005, the Secretary announced the formation of the 17-member American Health Information Community (AHIC), a public-private body formed pursuant to the Federal Advisory Committee Act to provide input and recommendations on facilitating the transition to interoperable electronic health records in a market-led way. AHIC's charter terminates after two years, unless the Secretary renews it for a duration of no more than five years. The Secretary intends for AHIC to be succeeded within five years by a private-sector health information community initiative that, among other things, would set additional needed standards, certify new health information technology, and provide long-term governance for health care transformation.

Explanation of Provision.

The bill would require the Secretary, within one year of enactment, to report to Congress on the work conducted by AHIC, including: (1) its promotion of the development of a nationwide health information network and the adoption of health IT; (2) information identifying the practices that are used to protect health information and to guarantee confidentiality and security of such information; and (3) progress in establishing nationwide health IT standards. The Secretary also would be required to include recommendations for the transition of AHIC to a permanent entity.

Reason for Change.

AHIC was formed to provide input and recommendations to HHS on how to make health records digital and interoperable, and assure that the privacy and security of those records are protected. It is important to understand the role AHIC plays in furthering the adoption of health IT and interoperability to justify the transition of AHIC to a permanent entity.

Effective Date.

Upon enactment.

Section 8. Strategic Plan for Coordinating Implementation of Health Information Technology.

Current Law.

Pursuant to Executive Order 13335 (see above), the National Coordinator for health IT, on July 21, 2004, released a strategic plan to guide the nationwide implementation of interoperable health IT in the public and private health care sectors.

Explanation of Provision.

The bill would require the Secretary, within 180 days of enactment and in coordination with entities involved in health IT, to develop a strategic plan for coordinating the implementation of health IT standards, HIPAA electronic transaction standards, and ICD-10 codes.

Reasons for Change.

HHS currently has numerous initiatives and offices involved in health information technology. The efforts of these offices need to be coordinated, and HHS must develop a strategic plan for moving forward in this area.

Effective Date.

Upon enactment.

Section 9. Promotion of Telehealth Services.

Current Law.

Effective October 1, 2001, the Medicare program covered professional consultations, office and other outpatient visits, individual psychotherapy, and pharmacologic management delivered via a telecommunications system. Effective March 1, 2003, the psychiatric diagnostic interview examination was added to this list of Medicare telehealth services [SSA § 1834 (m)(1)]. End stage renal disease-related services with two or more visits a month also was added to the list of Medicare telehealth services [*Final Rule*, 69 FR 66235, Nov. 15, 2004.]

Asynchronous “store and forward” technology can be used to deliver telehealth services when the originating site is a federal telemedicine demonstration program in Alaska or Hawaii. The originating site can be a physician or practitioner’s office, a critical access hospital, a rural health clinic, a federally qualified health center, or a hospital.

The physician or practitioner at the distant site must be licensed to provide the service under state law. Medicare covers telehealth services furnished by physicians, physician assistants, nurse practitioners, clinical nurse specialists, nurse-midwives, clinical psychologists, and clinical social workers.

Explanation of Provision.

This bill would require the Secretary to encourage and facilitate the adoption of State licensure agreements in order to provide telehealth services across state lines. The Secretary would report on the actions taken after 18 months of enactment of this bill. The Secretary would also be required to study the use of store and forward technology in the provision of telehealth services under the Medicare program. The study would include an assessment of the feasibility, advisability, and the costs of expanding the use of this technology in other areas besides Alaska and Hawaii.

This bill would also require the Secretary to study the feasibility, advisability and costs of expanding the list of originating sites to include home health agencies and county mental health clinics or other publicly funded mental health facilities. The Secretary would demonstrate that the expansion of sites enhances health outcomes for individuals with one or more chronic conditions, provides for comparable health outcomes to a face-to-face visit, facilitates better communication between providers, provides closer monitoring of patients, reduces overall healthcare costs, and improves access to care.

Reasons for Change.

Telehealth and telemonitoring services might enhance health outcomes for individuals with one or more chronic conditions, provide for comparable health outcomes to a face-to-face visit, facilitate better communication between providers, provide closer monitoring of patients, reduce overall healthcare costs, and improve access to care. These studies will help determine whether telehealth and telemonitoring services meet these objectives, and if so, would provide recommendations to either enhance the provision or coverage of telehealth services under the Medicare program.

Effective Date.

Upon enactment

III. VOTES OF THE SUBCOMMITTEE

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statements are made concerning the votes of the Committee on Ways and Means, Subcommittee on Health, in its consideration of the bill H.R. 4157.

A. MOTION TO REPORT THE BILL

The bill, H.R. 4157, was ordered favorably reported to the full Committee, as amended, by a recorded vote of 8 yeas to 5 nays.

<u>Representative</u>	<u>Yea</u>	<u>Nay</u>	<u>Present</u>	<u>Representative</u>	<u>Yea</u>	<u>Nay</u>	<u>Present</u>
Mrs. Johnson	X			Mr. Stark		X	
Mr. McCrery	X			Mr. Lewis		X	
Mr. Camp	X			Mr. Doggett		X	
Mr. Ramstad	X			Mr. Thompson		X	
Mr. English	X			Mr. Emanuel		X	
Mr. Hayworth	X						
Mr. Hulshof	X						

B. VOTES ON AMENDMENTS

Congressman Hulshof offered an amendment to the amendment in the nature of a substitute, which was agreed to by voice vote (with a quorum present).

Mr. Emanuel offered an amendment to the amendment in the nature of a substitute, which was defeated by a recorded vote of 8 nays to 4 yeas.

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mrs. Johnson		X		Mr. Stark	X		
Mr. McCrery		X		Mr. Lewis			
Mr. Camp		X		Mr. Doggett	X		
Mr. Ramstad		X		Mr. Thompson	X		
Mr. English		X		Mr. Emanuel	X		
Mr. Hayworth		X					
Mr. Hulshof		X					

Mr. English offered an amendment and then withdrew it from consideration.

Mr. Thompson offered an amendment to the amendment in the nature of a substitute, which was defeated by voice vote (with a quorum present).

Mr. Stark offered an amendment to the amendment in the nature of a substitute, which was defeated by a recorded of 8 nays to 5 yeas.

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mrs. Johnson		X		Mr. Stark	X		
Mr. McCrery		X		Mr. Lewis	X		
Mr. Camp		X		Mr. Doggett	X		
Mr. Ramstad		X		Mr. Thompson	X		
Mr. English		X		Mr. Emanuel	X		
Mr. Hayworth		X					
Mr. Hulshof		X					

Mr. Emanuel offered an amendment to the amendment in the nature of a substitute which was amended by Mr. Stark's amendment by unanimous consent. Mr. Emanuel/Stark's amendment was defeated by a recorded vote of 8 nays to 5 yeas.

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mrs. Johnson		X		Mr. Stark	X		
Mr. McCrery		X		Mr. Lewis	X		
Mr. Camp		X		Mr. Doggett	X		
Mr. Ramstad		X		Mr. Thompson	X		
Mr. English		X		Mr. Emanuel	X		
Mr. Hayworth		X					
Mr. Hulshof		X					

IV. BUDGET EFFECTS OF THE BILL

A. SUBCOMMITTEE ESTIMATE OF BUDGETARY EFFECTS

In compliance with clause 3(d)(2) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the bill, H.R. 4157 as amended and reported: The Subcommittee is working with the Congressional Budget Office to determine the impact on federal spending of the bill. The Subcommittee believes the legislation will reduce federal spending due to enhanced efficiencies and coordinated care.

B. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX EXPENDITURES BUDGET AUTHORITY

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Subcommittee states that H.R. 4157 does not include any significant new budget authority or tax expenditures.

C. COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET OFFICE

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives requiring a cost estimate prepared by the Congressional Budget Office, staff of the Congressional Budget Office are currently reviewing the legislation but have yet to make a final determination on the effect of the measure. CBO's complete cost estimate for H.R.4157, including the discretionary costs of the bill, will be provided shortly.