SEC. 4003. INTEROPERABILITY.

(a) DEFINITION.—Section 3000 of the Public Health Service Act (42 U.S.C. 300jj) is amended—

(1) by redesignating paragraphs (10) through (14), as paragraphs (11) through (15), respectively; and

(2) by inserting after paragraph (9) the following:

‘‘(10) INTEROPERABILITY.—The term ‘interoperability’, with respect to health information technology, means such health information technology that—

‘‘(A) enables the secure exchange of electronic health information with, and use of electronic health information from, other health information technology without special effort on the part of the user;

‘‘(B) allows for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable State or Federal law; and

‘‘(C) does not constitute information blocking as defined in section 3022(a).’’.

(b) SUPPORT FOR INTEROPERABLE NETWORK EXCHANGE.—Section 3001(c) of the Public Health Service Act (42 U.S.C. 300jj–11(c)) is amended by adding at the end the following:

‘‘(9) SUPPORT FOR INTEROPERABLE NETWORKS EXCHANGE.—

‘‘(A) IN GENERAL.—The National Coordinator shall, in collaboration with the National Institute of Standards and Technology and other relevant agencies within the Department of Health and Human Services, for the purpose of ensuring full network-to-network exchange of health information, convene public-private and public-public partnerships to build consensus and develop or support a trusted exchange framework, including a common agreement among health information networks nationally. Such convention may occur at a frequency determined appropriate by the Secretary.

‘‘(B) ESTABLISHING A TRUSTED EXCHANGE FRAMEWORK.—

‘‘(i) IN GENERAL.—Not later than 6 months after the date of enactment of the 21st Century Cures Act, the National Coordinator shall convene appropriate public and private stakeholders to develop or support a trusted exchange framework for trust policies and practices and for a common agreement for exchange between health information networks. The common agreement may include—

‘‘(I) a common method for authenticating trusted health information network participants;

‘‘(II) a common set of rules for trusted exchange;

‘‘(III) organizational and operational policies to enable the exchange of health information among networks, including minimum conditions for such exchange to occur; and

‘‘(IV) a process for filing and adjudicating noncompliance with the terms of the common agreement.

‘‘(ii) TECHNICAL ASSISTANCE.—The National Coordinator, in collaboration with the National Institute of

Standards and Technology, shall provide technical assistance on how to implement the trusted exchange framework and common agreement under this paragraph.

‘‘(iii) PILOT TESTING.—The National Coordinator, in consultation with the National Institute of Standards and Technology, shall provide for the pilot testing of the trusted exchange framework and common agreement established or supported under this subsection (as authorized under section 13201 of the Health Information Technology for Economic and Clinical Health Act). The National Coordinator, in consultation with the National Institute of Standards and Technology, may delegate pilot testing activities under this clause to independent entities with appropriate expertise.

‘‘(C) PUBLICATION OF A TRUSTED EXCHANGE FRAMEWORK AND COMMON AGREEMENT.—Not later than 1 year after convening stakeholders under subparagraph (A), the National Coordinator shall publish on its public Internet website, and in the Federal register, the trusted exchange framework and common agreement developed or supported under subparagraph (B). Such trusted exchange framework and common agreement shall be published in a manner that protects proprietary and security information, including trade secrets and any other protected intellectual property.

‘‘(D) DIRECTORY OF PARTICIPATING HEALTH INFORMATION NETWORKS.—

‘‘(i) IN GENERAL.—Not later than 2 years after convening stakeholders under subparagraph (A), and annually thereafter, the National Coordinator shall publish on its public Internet website a list of the health information networks that have adopted the common agreement and are capable of trusted exchange pursuant to the common agreement developed or supported under paragraph (B).

‘‘(ii) PROCESS.—The Secretary shall, through notice and comment rulemaking, establish a process for health information networks that voluntarily elect to adopt the trusted exchange framework and common agreement to attest to such adoption of the framework and agreement.

‘‘(E) APPLICATION OF THE TRUSTED EXCHANGE FRAMEWORK AND COMMON AGREEMENT.—As appropriate, Federal agencies contracting or entering into agreements with health information exchange networks may require that as each such network upgrades health information technology or trust and operational practices, such network may adopt, where available, the trusted exchange framework and common agreement published under subparagraph (C).

‘‘(F) RULE OF CONSTRUCTION.—

‘‘(i) GENERAL ADOPTION.—Nothing in this paragraph shall be construed to require a health information network to adopt the trusted exchange framework or common agreement.

‘‘(ii) ADOPTION WHEN EXCHANGE OF INFORMATION IS WITHIN NETWORK.—Nothing in this paragraph shall be construed to require a health information network to adopt the trusted exchange framework or common agreement for the exchange of electronic health information between participants of the same network.

''(iii) EXISTING FRAMEWORKS AND AGREEMENTS.—The trusted exchange framework and common agreement published under subparagraph (C) shall take into account existing trusted exchange frameworks and agreements used by health information networks to avoid the disruption of existing exchanges between participants of health information networks.

''(iv) APPLICATION BY FEDERAL AGENCIES.—Notwithstanding clauses (i), (ii), and (iii), Federal agencies may require the adoption of the trusted exchange framework and common agreement published under subparagraph (C) for health information exchanges contracting with or entering into agreements pursuant to subparagraph (E).

''(v) CONSIDERATION OF ONGOING WORK.—In carrying out this paragraph, the Secretary shall ensure the consideration of activities carried out by public and private organizations related to exchange between health information exchanges to avoid duplication of efforts.''.

(c) PROVIDER DIGITAL CONTACT INFORMATION INDEX.—

(1) IN GENERAL.—Not later than 3 years after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this subsection as the ''Secretary'') shall, directly or through a partnership with a private entity, establish a provider digital contact information index to provide digital contact information for health professionals and health facilities.

(2) USE OF EXISTING INDEX.—In establishing the initial index under paragraph (1), the Secretary may utilize an existing provider directory to make such digital contact information available.

(3) CONTACT INFORMATION.—An index established under this subsection shall ensure that contact information is available at the individual health care provider level and at the health facility or practice level.

(4) RULE OF CONSTRUCTION.—

(A) IN GENERAL.—The purpose of this subsection is to encourage the exchange of electronic health information by providing the most useful, reliable, and comprehensive index of providers possible. In furthering such purpose, the Secretary shall include all health professionals and health facilities applicable to provide a useful, reliable, and comprehensive index for use in the exchange of health information.

(B) LIMITATION.—In no case shall exclusion from the index of providers be used as a measure to achieve objectives other the objectives described in subparagraph (A).

(d) STANDARDS DEVELOPMENT ORGANIZATIONS.—Section 3004 of the Public Health Service Act (42 U.S.C. 300jj–14) is amended by adding at the end the following:

''(c) DEFERENCE TO STANDARDS DEVELOPMENT ORGANIZATIONS.— In adopting and implementing standards under this section, the Secretary shall give deference to standards published by standards development organizations and voluntary consensus-based standards bodies.''.

(e) HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE.—

(1) IN GENERAL.—Title XXX of the Public Health Service Act (42 U.S.C. 300jj et seq.) is amended by striking sections 3002 (42 U.S.C. 300jj–12) and 3003 (42 U.S.C. 300jj–13) and inserting the following:

''SEC. 3002. HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE.

''(a) ESTABLISHMENT.—There is established a Health Information Technology Advisory Committee (referred to in this section as the 'HIT Advisory Committee') to recommend to the National Coordinator, consistent with the implementation of the strategic plan described in section 3001(c)(3), policies, and, for purposes of adoption under section 3004, standards, implementation specifications, and certification criteria, relating to the implementation of a health information technology infrastructure, nationally and locally, that advances the electronic access, exchange, and use of health information. Such Committee shall serve to unify the roles of, and replace, the HIT Policy Committee and the HIT Standards Committee, as in existence before the date of the enactment of the 21st Century Cures Act.

''(b) DUTIES.—

''(1) RECOMMENDATIONS ON POLICY FRAMEWORK TO ADVANCE AN INTEROPERABLE HEALTH INFORMATION TECHNOLOGY INFRASTRUCTURE.—

''(A) IN GENERAL.—The HIT Advisory Committee shall recommend to the National Coordinator a policy framework for adoption by the Secretary consistent with the strategic plan under section 3001(c)(3) for advancing the target areas described in this subsection. Such policy framework shall seek to prioritize achieving advancements in the target areas specified in subparagraph (B) of paragraph (2) and may, to the extent consistent with this section, incorporate policy recommendations made by the HIT Policy Committee, as in existence before the date of the enactment of the 21st Century Cures Act.

''(B) UPDATES.—The HIT Advisory Committee shall propose updates to such recommendations to the policy framework and make new recommendations, as appropriate.

''(2) GENERAL DUTIES AND TARGET AREAS.—

''(A) IN GENERAL.—The HIT Advisory Committee shall recommend to the National Coordinator for purposes of adoption under section 3004, standards, implementation specifications, and certification criteria and an order of priority for the development, harmonization, and recognition of such standards, specifications, and certification criteria. Such recommendations shall include recommended standards, architectures, and software schemes for access to electronic individually identifiable health information across disparate systems including user vetting, authentication, privilege management, and access control.

''(B) PRIORITY TARGET AREAS.—For purposes of this section, the HIT Advisory Committee shall make recommendations under subparagraph (A) with respect to at least each of the following target areas:

‘‘(i) Achieving a health information technology infrastructure, nationally and locally, that allows for the electronic access, exchange, and use of health information, including through technology that provides accurate patient information for the correct patient, including exchanging such information, and avoids the duplication of patient records.

‘‘(ii) The promotion and protection of privacy and security of health information in health information technology, including technologies that allow for an accounting of disclosures and protections against disclosures of individually identifiable health information made by a covered entity for purposes of treatment, payment, and health care operations (as such terms are defined for purposes of the regulation promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996), including for the segmentation and protection from disclosure of specific and sensitive individually identifiable health information with the goal of minimizing the reluctance of patients to seek care.

‘‘(iii) The facilitation of secure access by an individual to such individual’s protected health information and access to such information by a family member, caregiver, or guardian acting on behalf of a patient, including due to age-related and other disability, cognitive impairment, or dementia.

‘‘(iv) Subject to subparagraph (D), any other target area that the HIT Advisory Committee identifies as an appropriate target area to be considered under this subparagraph.

‘‘(C) ADDITIONAL TARGET AREAS.—For purposes of this section, the HIT Advisory Committee may make recommendations under subparagraph (A), in addition to areas described in subparagraph (B), with respect to any of the following areas:

‘‘(i) The use of health information technology to improve the quality of health care, such as by promoting the coordination of health care and improving continuity of health care among health care providers, reducing medical errors, improving population health, reducing chronic disease, and advancing research and education.

‘‘(ii) The use of technologies that address the needs of children and other vulnerable populations.

‘‘(iii) The use of electronic systems to ensure the comprehensive collection of patient demographic data, including at a minimum, race, ethnicity, primary language, and gender information.

‘‘(iv) The use of self-service, telemedicine, home health care, and remote monitoring technologies.

‘‘(v) The use of technologies that meet the needs of diverse populations.

‘‘(vi) The use of technologies that support—

‘‘(I) data for use in quality and public reporting programs;

‘‘(II) public health; or

‘‘(III) drug safety.

‘‘(vii) The use of technologies that allow individually identifiable health information to be rendered unusable, unreadable, or indecipherable to unauthorized individuals when such information is transmitted in a health information network or transported outside of the secure facilities or systems where the disclosing covered entity is responsible for security conditions.

‘‘(viii) The use of a certified health information technology for each individual in the United States.

‘‘(D) AUTHORITY FOR TEMPORARY ADDITIONAL PRIORITY TARGET AREAS.—For purposes of subparagraph (B)(iv), the HIT Advisory Committee may identify an area to be considered for purposes of recommendations under this subsection as a target area described in subparagraph (B) if—

‘‘(i) the area is so identified for purposes of responding to new circumstances that have arisen in the health information technology community that affect the interoperability, privacy, or security of health information, or affect patient safety; and

‘‘(ii) at least 30 days prior to treating such area as if it were a target area described in subparagraph

(B), the National Coordinator provides adequate notice to Congress of the intent to treat such area as so described.

‘‘(E) FOCUS OF COMMITTEE WORK.—It is the sense of Congress that the HIT Advisory Committee shall focus its work on the priority areas described in subparagraph (B) before proceeding to other work under subparagraph (C).

‘‘(3) RULES RELATING TO RECOMMENDATIONS FOR STANDARDS, IMPLEMENTATION SPECIFICATIONS, AND CERTIFICATION CRITERIA.—

‘‘(A) IN GENERAL.—The HIT Advisory Committee shall recommend to the National Coordinator standards, implementation specifications, and certification criteria described in subsection (a), which may include standards, implementation specifications, and certification criteria that have been developed, harmonized, or recognized by the HIT Advisory Committee or predecessor committee. The HIT Advisory Committee shall update such recommendations and make new recommendations as appropriate, including in response to a notification sent under section 3004(a)(2)(B). Such recommendations shall be consistent with the latest recommendations made by the Committee.

‘‘(B) HARMONIZATION.—The HIT Advisory Committee may recognize harmonized or updated standards from an entity or entities for the purpose of harmonizing or updating standards and implementation specifications in order to achieve uniform and consistent implementation of the standards and implementation specification.

‘‘(C) PILOT TESTING OF STANDARDS AND IMPLEMENTATION SPECIFICATIONS.—In the development, harmonization, or recognition of standards and implementation specifications, the HIT Advisory Committee for purposes of recommendations under paragraph (2)(B), shall, as appropriate, provide for the testing of such standards and specifications by the National Institute for Standards and Technology under section 13201(a) of the Health Information Technology for Economic and Clinical Health Act.

‘‘(D) CONSISTENCY.—The standards, implementation specifications, and certification criteria recommended under paragraph (2)(B) shall be consistent with the standards for information transactions and data elements adopted pursuant to section 1173 of the Social Security Act.

‘‘(E) SPECIAL RULE RELATED TO INTEROPERABILITY.— Any recommendation made by the HIT Advisory Committee after the date of the enactment of this subparagraph with respect to interoperability of health information technology shall be consistent with interoperability as described in section 3000.

‘‘(4) FORUM.—The HIT Advisory Committee shall serve as a forum for the participation of a broad range of stakeholders with specific expertise in policies, including technical expertise, relating to the matters described in paragraphs (1), (2), and (3) to provide input on the development, harmonization, and recognition of standards, implementation specifications, and certification criteria necessary for the development and adoption of health information technology infrastructure nationally and locally that allows for the electronic access, exchange, and use of health information.

‘‘(5) SCHEDULE.—Not later than 30 days after the date on which the HIT Advisory Committee first meets, such HIT Advisory Committee shall develop a schedule for the assessment of policy recommendations developed under paragraph (1). The HIT Advisory Committee shall update such schedule annually. The Secretary shall publish such schedule in the Federal Register.

‘‘(6) PUBLIC INPUT.—The HIT Advisory Committee shall conduct open public meetings and develop a process to allow for public comment on the schedule described in paragraph (5) and recommendations described in this subsection. Under such process comments shall be submitted in a timely manner after the date of publication of a recommendation under this subsection.

‘‘(c) MEASURED PROGRESS IN ADVANCING PRIORITY AREAS.—

‘‘(1) IN GENERAL.—For purposes of this section, the National Coordinator, in collaboration with the Secretary, shall establish, and update as appropriate, objectives and benchmarks for advancing and measuring the advancement of the priority target areas described in subsection (b)(2)(B).

‘‘(2) ANNUAL PROGRESS REPORTS ON ADVANCING INTEROPERABILITY.—

‘‘(A) IN GENERAL.—The HIT Advisory Committee, in consultation with the National Coordinator, shall annually submit to the Secretary and Congress a report on the progress made during the preceding fiscal year in—

‘‘(i) achieving a health information technology infrastructure, nationally and locally, that allows for the electronic access, exchange, and use of health information; and

‘‘(ii) meeting the objectives and benchmarks described in paragraph (1).

‘‘(B) CONTENT.—Each such report shall include, for a fiscal year—

‘‘(i) a description of the work conducted by the HIT Advisory Committee during the preceding fiscal year with respect to the areas described in subsection (b)(2)(B);

‘‘(ii) an assessment of the status of the infrastructure described in subparagraph (A), including the extent to which electronic health information is appropriately and readily available to enhance the access, exchange, and the use of electronic health information between users and across technology offered by different developers;

‘‘(iii) the extent to which advancements have been achieved with respect to areas described in subsection (b)(2)(B);

‘‘(iv) an analysis identifying existing gaps in policies and resources for—

‘‘(I) achieving the objectives and benchmarks established under paragraph (1); and

‘‘(II) furthering interoperability throughout the health information technology infrastructure;

‘‘(v) recommendations for addressing the gaps identified in clause (iii); and

‘‘(vi) a description of additional initiatives as the HIT Advisory Committee and National Coordinator determine appropriate.

‘‘(3) SIGNIFICANT ADVANCEMENT DETERMINATION.—The Secretary shall periodically, based on the reports submitted under this subsection, review the target areas described in subsection (b)(2)(B), and, based on the objectives and benchmarks established under paragraph (1), the Secretary shall determine if significant advancement has been achieved with respect to such an area. Such determination shall be taken into consideration by the HIT Advisory Committee when determining to what extent the Committee makes recommendations for an area other than an area described in subsection (b)(2)(B).

‘‘(d) MEMBERSHIP AND OPERATIONS.—

‘‘(1) IN GENERAL.—The National Coordinator shall take a leading position in the establishment and operations of the HIT Advisory Committee.

‘‘(2) MEMBERSHIP.—The membership of the HIT Advisory Committee shall—

‘‘(A) include at least 25 members, of which—

‘‘(i) no fewer than 2 members are advocates for patients or consumers of health information technology;

‘‘(ii) 3 members are appointed by the Secretary, 1 of whom shall be appointed to represent the Department of Health and Human Services and 1 of whom shall be a public health official;

‘‘(iii) 2 members are appointed by the majority leader of the Senate;

‘‘(iv) 2 members are appointed by the minority leader of the Senate;

‘‘(v) 2 members are appointed by the Speaker of the House of Representatives;

‘‘(vi) 2 members are appointed by the minority leader of the House of Representatives; and

‘‘(vii) such other members are appointed by the Comptroller General of the United States; and

‘‘(B) at least reflect providers, ancillary health care workers, consumers, purchasers, health plans, health information technology developers, researchers, patients, relevant Federal agencies, and individuals with technical expertise on health care quality, system functions, privacy, security, and on the electronic exchange and use of health information, including the use standards for such activity.

‘‘(3) PARTICIPATION.—The members of the HIT Advisory Committee shall represent a balance among various sectors of the health care system so that no single sector unduly influences the recommendations of the Committee.

‘‘(4) TERMS.—

‘‘(A) IN GENERAL.—The terms of the members of the HIT Advisory Committee shall be for 3 years, except that the Secretary shall designate staggered terms of the members first appointed.

‘‘(B) VACANCIES.—Any member appointed to fill a vacancy in the membership of the HIT Advisory Committee that occurs prior to the expiration of the term for which the member’s predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member’s term until a successor has been appointed. A vacancy in the HIT Advisory Committee shall be filled in the manner in which the original appointment was made.

‘‘(C) LIMITS.—Members of the HIT Advisory Committee shall be limited to two 3-year terms, for a total of not to exceed 6 years of service on the Committee.

‘‘(5) OUTSIDE INVOLVEMENT.—The HIT Advisory Committee shall ensure an opportunity for the participation in activities of the Committee of outside advisors, including individuals with expertise in the development of policies and standards for the electronic exchange and use of health information, including in the areas of health information privacy and security.

‘‘(6) QUORUM.—A majority of the members of the HIT Advisory Committee shall constitute a quorum for purposes of voting, but a lesser number of members may meet and hold hearings.

‘‘(7) CONSIDERATION.—The National Coordinator shall ensure that the relevant and available recommendations and comments from the National Committee on Vital and Health Statistics are considered in the development of policies.

‘‘(8) ASSISTANCE.—For the purposes of carrying out this section, the Secretary may provide or ensure that financial assistance is provided by the HIT Advisory Committee to defray in whole or in part any membership fees or dues charged by such Committee to those consumer advocacy groups and not-for-profit entities that work in the public interest as a party of their mission.

‘‘(e) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.), other than section 14 of such Act, shall apply to the HIT Advisory Committee.

''(f) PUBLICATION.—The Secretary shall provide for publication in the Federal Register and the posting on the Internet website of the Office of the National Coordinator for Health Information Technology of all policy recommendations made by the HIT Advisory Committee under this section.''.

(2) TECHNICAL AND CONFORMING AMENDMENTS.—Title XXX of the Public Health Service Act (42 U.S.C. 300jj et seq.) is amended—

(A) by striking—

(i) ''HIT Policy Committee'' and ''HIT Standards Committee'' each place that such terms appear (other than within the term ''HIT Policy Committee and the HIT Standards Committee'' or within the term ''HIT Policy Committee or the HIT Standards Committee'') and inserting ''HIT Advisory Committee'';

(ii) ''HIT Policy Committee and the HIT Standards Committee'' each place that such term appears and inserting ''HIT Advisory Committee''; and

(iii) ''HIT Policy Committee or the HIT Standards Committee'' each place that such term appears and inserting ''HIT Advisory Committee'';

(B) in section 3000 (42 U.S.C. 300jj)—

(i) by striking paragraphs (7) and (8) and redesignating paragraphs (9) through (14) as paragraphs (8) through (13), respectively; and

(ii) by inserting after paragraph (6) the following paragraph:

''(7) HIT ADVISORY COMMITTEE.—The term 'HIT Advisory Committee' means such Committee established under section 3002(a).'';

(C) in section 3001(c) (42 U.S.C. 300jj–11(c))—

(i) in paragraph (1)(A), by striking ''under section 3003'' and inserting ''under section 3002'';

(ii) in paragraph (2), by striking subparagraph (B) and inserting the following:

''(B) HIT ADVISORY COMMITTEE.—The National Coordinator shall be a leading member in the establishment and operations of the HIT Advisory Committee and shall serve as a liaison between that Committee and the Federal Government.'';

(D) in section 3004(b)(3) (42 U.S.C. 300jj–14(b)(3)), by striking ''3003(b)(2)'' and inserting ''3002(b)(4)'';

(E) in section 3007(b) (42 U.S.C. 300jj–17(b)), by striking ''3003(a)'' and inserting ''3002(a)(2)''; and

(F) in section 3008 (42 U.S.C. 300jj–18)—

(i) in subsection (b), by striking ''or 3003''; and

(ii) in subsection (c), by striking ''3003(b)(1)(A)'' and inserting ''3002(b)(2)''.

(3) TRANSITION TO THE HIT ADVISORY COMMITTEE.—The Secretary of Health and Human Services shall provide for an orderly and timely transition to the HIT Advisory Committee established under amendments made by this section.

(f) PRIORITIES FOR ADOPTION OF STANDARDS, IMPLEMENTATION SPECIFICATIONS, AND CERTIFICATION CRITERIA.—Title XXX of the Public Health Service Act (42 U.S.C. 300jj et seq.), as amended by subsection (e), is further amended by inserting after section 3002 the following:

''SEC. 3003. SETTING PRIORITIES FOR STANDARDS ADOPTION.

''(a) IDENTIFYING PRIORITIES.—

''(1) IN GENERAL.—Not later than 6 months after the date on which the HIT Advisory Committee first meets, the National Coordinator shall periodically convene the HIT Advisory Committee to—

''(A) identify priority uses of health information technology, focusing on priorities—

''(i) arising from the implementation of the incentive programs for the meaningful use of certified HER technology, the Merit-based Incentive Payment System, Alternative Payment Models, the Hospital Value-Based Purchasing Program, and any other value-based payment program determined appropriate by the Secretary;

''(ii) related to the quality of patient care;

''(iii) related to public health;

''(iv) related to clinical research;

''(v) related to the privacy and security of electronic health information;

''(vi) related to innovation in the field of health information technology;

''(vii) related to patient safety;

''(viii) related to the usability of health information technology;

''(ix) related to individuals' access to electronic health information; and

''(x) other priorities determined appropriate by the Secretary;

''(B) identify existing standards and implementation specifications that support the use and exchange of electronic health information needed to meet the priorities identified in subparagraph (A); and

''(C) publish a report summarizing the findings of the analysis conducted under subparagraphs (A) and (B) and make appropriate recommendations.

‘‘(2) PRIORITIZATION.—In identifying such standards and implementation specifications under paragraph (1)(B), the HIT Advisory Committee shall prioritize standards and implementation specifications developed by consensus-based standards development organizations.

‘‘(3) GUIDELINES FOR REVIEW OF EXISTING STANDARDS AND SPECIFICATIONS.—In consultation with the consensus-based entity described in section 1890 of the Social Security Act and other appropriate Federal agencies, the analysis of existing standards under paragraph (1)(B) shall include an evaluation of the need for a core set of common data elements and associated value sets to enhance the ability of certified health information technology to capture, use, and exchange structured electronic health information.

‘‘(b) REVIEW OF ADOPTED STANDARDS.—

‘‘(1) IN GENERAL.—Beginning 5 years after the date of enactment of the 21st Century Cures Act and every 3 years thereafter, the National Coordinator shall convene stakeholders to review the existing set of adopted standards and implementation specifications and make recommendations with respect to whether to—

‘‘(A) maintain the use of such standards and implementation specifications; or

‘‘(B) phase out such standards and implementation specifications.

‘‘(2) PRIORITIES.—The HIT Advisory Committee, in collaboration with the National Institute for Standards and Technology, shall annually and through the use of public input, review and publish priorities for the use of health information technology, standards, and implementation specifications to support those priorities.

‘‘(c) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to prevent the use or adoption of novel standards that improve upon the existing health information technology infrastructure and facilitate the secure exchange of health information.’’.