The Department of Education applies provisions concerning change of institutional ownership to nonprofit institutions, despite clear expression of contrary congressional intent. The common understanding that nonprofit institutions do not have owners. This places unnecessary burdens on institutions, and may act as a deterrent to governance changes necessary to make institutions more efficient and effective.

(2) Disclosure of Foreign Gifts
When an institution receives a foreign gift in excess of $250,000 they must report it to the federal government. This data is publicly available in the annual reports prepared by every college and university and is carefully monitored for public institutions by state governments. The Department of Education reports that it never gets public requests for this information. Institutions will no longer be required to provide this information to the federal government, but make it publicly available on an annual basis.

By Mr. FRIST (for himself, Mrs. CLINTON, Mr. MARTINEZ, Mr. BINGAMAN, Mr. TALENT, Ms. MIKULSKI, Mr. THUNE, and Mr. ONDRIS).

S. 1262. A bill to reduce healthcare costs, improve efficiency, and improve healthcare quality through the development of a nation-wide interoperable health information technology system, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mr. FRIST. Mr. President, this morning I am pleased to be joined on the floor by my distinguished colleague from the great state of New York, Senator Clinton. Together, we share an important goal to improve health care quality and reduce costs through the use of health information technology tools.

I had the wonderful opportunity of spending 20 years as a physician and as a heart surgeon before coming to this body. Like most physicians, I wanted to and, in fact, did use the very latest, most advanced technology, anything that could possibly, in my practice, make my patients live a healthier life, a better life, a more comfortable life.

But amidst the artificial heart assist devices, the lasers that are used to remove lesions in the windpipe or the trachea, CT scan machines, x-rays, digital x-rays, digital thermometers, doctors today, unfortunately, for the most part, keep patient records the very same way I did 10 years ago and, indeed, almost exactly as my dad did 60 years ago as he practiced medicine, and that is handwritten on paper in manila folders stored in the upper floors of clinics or doctors’ offices or hospitals.

It is amazing because we design hospitals, structures on computers today, we conduct medical research with computers, we use computers almost everything we use, everything we do in terms of diagnosis in medicine, in health care.

But—and this is what we have come to the floor to address—when it comes to health information, when it comes to electronic medical records, we are in the stone age and not the information age.

Imagine a traveler far away from home who gets in an automobile accident and is taken unconscious orconscious to the hospital. Paramedics rush them to a hospital, and at the very moment that individual arrives at the door of that emergency room, the emergency room physician meets them, but empty-handed, with no notification of their medical history or preexisting illnesses, all of which is potentially lifesaving information. That is inexcusable in this day and age.

My colleague from New York knows this all too well.

Mrs. CLINTON. Mr. President, I wish to express my appreciation to Senator Frist for his leadership on this issue because we certainly do need to bring our health care system out of the information dark ages. I am pleased to be introducing this legislation today with the majority leader. It is a priority for both of us, and I look forward to continuing our partnership to move this legislation through the legislative process.

For several years, I have been promoting the adoption of health information technology as a means to improve our health care system and bring it into the 21st century. I introduced health and information technology legislation in 2003 to jump-start the conversation on health IT. I am very pleased that I have had the opportunity now to work with the majority leader for more than a year on realizing what we believe would work, that would enable patients, physicians, nurses, hospitals—all—to have access electronically in a privacy-protected way to health information.

We have a lot of challenges facing us in health care. We have a long way to go to achieve the goal of expanding access to quality, affordable health care for all Americans. But creating a health information technology infrastructure needs to be a key part of achieving our health care goals because we are facing an escalating health care crisis.

Information technology has radically changed business and other aspects of our lives. It is time to use it to bring our health sector into the information age.

Currently, the health industry spends 2 to 3 percent of its revenues on information technology, compared to roughly 12 percent in industries such as finance or banking. That is why you cannot go to an ATM, go to the bank, and you cannot find out anywhere in the world and access money from your bank account.

But despite evidence that greater investments could yield returns, we have not put in place the necessary infrastructure to facilitate the necessary investment in an interoperable health information technology and quality infrastructure.

Mr. FRIST. Mr. President, this needs to change and it must change. We must establish an interoperable privacy-protected electronic medical record for every American who wants one. Working together, our Nation can confront these challenges, and we can build an interoperable health information technology system. We know it will save lives. We know it will save money. It will improve quality and it will lead to huge measurable progress in the medical field, in the health field.

We face enormous problems as a result of the underinvestment in health information technology. No industry as important to our economy as health spends as little on information technology. Our Nation has nearly 900,000 doctors and over 2.8 million nurses. Americans visit a doctor 900 million times per year. We have nearly 6,000 hospitals all over the country. Our health care system is enormous, yes, but it is dangerously fragmented. Even small improvements in efficiency can greatly reduce cost and improve quality, and there is plenty of room for improvement.

Mrs. CLINTON. Mr. President, I could not agree more. The majority comes to this debate with a lifetime of experience and expertise. Researchers at Dartmouth University found that we waste as much as one-third of the $1.8 trillion we spend on health care on care that is not necessary.

Doctors write over 2 billion prescriptions each year by hand. With all respect to my doctors, some are unclear or even illegible. Handwritten prescriptions filled incorrectly result in as many as 7,000 deaths each year because we do not have access to a fail-safe system so that providing the prescription electronically, which also would trigger a response if it was interacting with another drug the patient was taking or had yet available.

With that data, it is difficult, sometimes even impossible, to track the quality of care patients receive. We cannot reward good providers or work to improve those who provide inferior care.

Widening health care disparities really are a growing problem in our society. It is especially important because every moment that a doctor or a nurse spends with a patient is precious. For every hour that they spend with a patient, they spend one-half hour filling out those forms by hand. So we can save time, we can save money, and we can make it clear that this information will be easily electronically transportable where it is needed.

Mr. FRIST. The problem is enormous and the problem is real. So what are we going to do about it? Senator Clinton and I propose three concrete steps to remedy these problems and establish a fully interoperable information technology system. First, we must establish standards for electronic medical records. Sharing data effectively requires more than just that fiber optic
May 16, 2005

CONGRESSIONAL RECORD—SENATE

S6753

cable, more than those Internet con-
nections. It requires standards and
laws that make it possible to exchange
medical information in a privacy-pro-
tected way throughout our Nation.

The Government should not impose
these high standards on the private
sector, but it has a duty, and indeed it has an
obligation, to lead the way. Medicare,
Medicaid, SCHIP, the Indian Health
Service, and other Federal programs
should lead the way and establish elec-
tronic health records for all of their
clients.

The Veterans’ Administration al-
ready leads the way with interoperable
systems, but we need to get the VA to be
able to talk to the Department of
Defense.

Mrs. CLINTON. That is absolutely
the case, especially as we tragically
know so many young people who have
been injured in Iraq or Afghanistan
move from the DOD to the VA. We
have to have a better system so that they
will not lose the information that needs to
tell the story for these brave young men and women.

Secondly, we believe our legislation
should work to reduce barriers and fa-
cilitate the electronic exchange of
health information among providers in
a secure and private way to improve
health care quality and meet commu-
nity needs. When communities come
together, as is beginning to happen all
over the country, the Federal Govern-
ment should help them implement an
interoperable health IT system.

Interoperable sounds like a confusing
word, but it means they can talk to
each other, they can operate in the
same overall system and do it in a way
that complies with national standards.

To speed up this process, we propose
spending a total of $600 million—$125
million a year, over 5 years—to begin
the work of rolling out interoperable
electronic medical records systems
around the Nation.

Firstly, we must use the data we collect
to focus intensely on improving the
quality of health care. Our medical
system, which is, and deserves to be,
the envy of the world, still suffers from
einormous and unpardonable disparities
in the quality of care. Health IT will be
a tool to help our dedicated health care
professionals improve care, and effi-
ciently, so that they spend more time
at the bedside, more time at the office
visit, and less on paperwork.

The Americans, we will begin to collect consistent data on the
quality of health care delivered in
America. As the largest health care
payer in the country, the Federal Gov-
ernment has a responsibility to begin
that process of collecting data on its
own health care programs and share it
with the public. Then, with this data,
we can begin to move to a health care
system that actually rewards providers
who give their patients superior care.

Mr. FRIST. Mr. President, as we talk
about these systems and standards and
words such as interoperability, which,
as the Senator from New York said,
does mean being able to connect it all
together, people who are listening
must ask: Well, how in the world do
these electronic health records and the
appropriate use of that data bring con-
crete benefits to them as individuals
and to their families?

First, the electronic system will create a
great deal of waste and ineffi-
cency in the system. It only makes
sense that fragmented systems, with
no interconnectivity at all, have inher-
ent inefficiencies and waste. That is
moved aside. That has a very direct im-
 pact on lower costs, making health
care more affordable and thus available
for people broadly.

It improves quality. Right now we
know that medical errors occur. Too
many medical errors occur in our
health care system today. By the appli-
cation of technology, we can move these
medical errors aside. They will not
occur and that improves quality.

They will empower patients. It gives
that individual who is listening right
now the knowledge and power to be
able to participate in a consumer-driv-
en system where choices can be made,
where the focus is on the patient, that
is provider friendly, that is driven by
information and choice and empower-
ment to make that choice.

They will also protect privacy and
promote the secure exchange of life-
saving health information. It is spelled
out in the legislation. It is going to be
privacy protected.

For the first time, they will
seamlessly integrate this advancement
in health information technology with
quality measures, with quality ad-
vancements, harmonizing and inte-
grating them in a way that simply has
not been done in the past.

This proposal brings together people,
as we can see, from across the political
spectrum, and it will unlock the poten-
tial of medical information technology
for all Americans.

Mrs. CLINTON. I am delighted to be
working on this very important na-
sion. Technology but to the collection of infor-
mation, and the appropriate sharing of that information which is
more and more available...
in concert with the President of the United States to make sure that the
great advantages, in terms of lowering
costs, getting rid of inefficiencies, and
promoting quality will be realized.
The bill that we will shortly intro-
duce is for all Americans.
Again, I thank my distinguished
colleague from New York. We urge all of
our colleagues to look at this bill and
support this bill. With this legislation,
there is no doubt in my mind that we
will, yes, help save money and help
save time, but most importantly we
will save lives.
I ask unanimous consent that the
text of the bill we will shortly send to
the desk be printed in the RECORD.
Mr. President, I am proud to join Senators FRIST and CLIN-
TON in introducing the Health Tech-
nology to Enhance Quality Act of 2005.
Our national health care system is in
crisis. Forty-five million Americans are
without health insurance, and this number
continues to rise. Health care costs are
increasing at almost double digit rates.
Millions of Americans are suffering,
and dying, from diseases such as diabe-
tes or AIDS that could have been pre-
vented when delayed for many years. And
the chance of Americans receiving the
right care, at the right time and for
the right reason is no greater than the
flip of a coin.
These health care issues are varied
and complex, as are the solutions. But,
as one of my constituents advised, it is
time for us in the Congress to put on
our hard hats, pick up our tool belts and
get to work fixing our broken health care
system.
One place to start is by bringing the
health care system into the 21st cen-
tury. In our lifetimes, we have seen
some of the greatest advances in the
history of technology and the sharing
of information. Yet, in our health care
system, too much care is still provided
with a pen and paper. Too much infor-
mation about patients is not shared be-
tween doctors or readily available to
them in the first place. And providers
too often do not have the information
to know what care has worked most ef-
fectively and efficiently to make pa-
tients healthy.
Mistakes are easily made—medical
errors alone kill up to 98,000 people a
year, more people than the number
who die from AIDS each year.
But one thing 21st century tech-
nology is not just about reducing er-
rors and improving the quality of med-
care. It is also about cost.
We spend nearly $1.5 trillion a year
on health care in America. But a quar-
ter of that money—one out of every
four dollars—is spent on non-medical
costs—most of it on bills and paper-
work. Every transaction you make at a
bank now costs them less than a penny.
Yet, because we have not updated tech-
nology in the rest of the health care in-
dustry, a single transaction still costs
up to $25—not one dime of which goes
toward improving the quality of our
health care.
The Health Technology to Enhance
Quality Act of 2005 is going to help
bring the health care system into the
21st century. This bill will lead to the
development and implementation of
health information technology stand-
ards of measure interoperability of
health information systems. The legis-
lation codifies the Office of National
Coordinator for Information Tech-
nology and establishes standards for
the electronic exchange of health infor-
mation. The bill also provides grant
funding to support development of
health information technology infra-
structure as well as measurement of
the quality of care provided to pa-
tients.
This legislation will help our health
care system take a huge step forward.
A vote for the Health TEQ Act is a vote
for health care that is safe, effective,
and affordable. I urge my colleagues to
join us in passing this bill quickly.
There being no objection, the bill was
ordered to be printed in the RECORD, as
follows:
S. 1362
Be it enacted by the Senate and House of
Representatives of the United States of America in
Congress assembled,
SECTION 1. SHORT TITLE.
This Act may be cited as the “Health
Technology to Enhance Quality Act of 2005”
or the “Health TEQ Act of 2005”.
TITLE I—HEALTH INFORMATION TECH-
NOLOGY STANDARDS ADOPTION AND
INFRASTRUCTURE DEVELOPMENT
SEC. 101. ESTABLISHMENT OF NATIONAL COOR-
MINATOR; RECOMMENDATION, ADOPTION,
AND IMPLEMENTATION OF HEALTH INFOR-
MATION ELECTRONIC EXCHANGE STANDARDS.
The Public Health Service Act (42 U.S.C.
201 et seq.) is amended by adding at the end
the following:
“TITLE XXIX—HEALTH INFORMATION
TECHNOLOGY
“SEC. 2901. DEFINITIONS.
For purposes of this title:
(1) GROUP HEALTH PLAN.—The term ‘group
health plan’ has the meaning giving that
term in section 2791.
(2) HEALTHCARE PROVIDER.—The term
‘healthcare provider’ means a provider of
health care, including public or private
health facilities, group practices, solo
practitioners, and any other type of
healthcare provider.
(3) HEALTH INFORMATION.—The term
‘health information’ means any information,
recorded in any form or medium, that relates
to the past, present, or future physical or
mental health or condition of an individual,
including the provision of healthcare to an
individual, or the past, present, or future payment
for the provision of healthcare to an individual.
(4) HEALTH CARE INSURANCE.—The term
‘health care insurance’ has the meaning
given that term in section 2791.
private parties of interest, including consumers, payers, employers, hospitals and other health care providers, physicians, community health centers, laboratories, vendors and other stakeholders;

“(G) advise the President regarding specific Federal health information technology programs; and

“(H) include in the reports described under paragraph (2).

“(2) REPORTS TO CONGRESS.—The National Coordinator shall submit to Congress, on an annual basis, a report that describes—

“(A) specific steps that have been taken to facilitate the adoption of a nationwide system for the electronic exchange of health information;

“(B) barriers to the adoption of such a nationwide system; and

“(C) recommendations to achieve full implementation of such a nationwide system.

“(d) DETAIL OF FEDERAL EMPLOYEES.—

“(1) IN GENERAL.—Upon the request of the National Coordinator, the head of any Federal agency is authorized to detail, with or without reimbursement from the Office, any of the personnel of such agency to the Office to assist it in carrying out its duties under this section.

“(2) EFFECT OF DETAIL.—Any such detail shall—

“(A) not interrupt or otherwise affect the civil service status or privileges of the Federal employee; and

“(B) in addition to any other staff of the Department employed by the National Coordinator.

“(3) ACCEPTANCE OF DETAILERS.—Notwithstanding any other provision of law, the Office may accept detailed personnel from other Federal agencies without regard to whether the agency described under paragraph (1) is reimbursed.

“(e) AUTHORIZATION OF APROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the activities of the Office under this section for each of fiscal years 2006 through 2010.

“SEC. 2903. COLLABORATIVE PROCESS FOR THE REGULATORY ADOPTION AND IMPLEMENTATION OF HEALTH INFORMATION STANDARDS.

“(a) ESTABLISHMENT OF WORKING GROUP.—Not later than 60 days after the date of enactment of this title, the National Coordinator, in consultation with the Director of the National Institute of Standards and Technology (referred to in this section as the ‘Director’), shall establish a permanent Electronic Health Information Standards Development Working Group (referred to in this title as the ‘Standards Working Group’).

“(b) COMPOSITION.—The Standards Working Group shall be composed of—

“(1) the National Coordinator, who shall serve as the chairperson of the Standards Working Group;

“(2) the Director;

“(3) representatives of the relevant Federal agencies and departments, as selected by the Secretary in consultation with the National Coordinator, representatives of the Department of Veterans Affairs, the Department of Defense, the Office of Management and Budget, the Department of Homeland Security, and the Environmental Protection Agency;

“(4) private entities accredited by the American National Standards Institute, as selected by the National Coordinator;

“(5) representatives, as selected by the National Coordinator—

“(A) of the Health plans or other health insurance issuers;

“(B) of healthcare provider organizations;

“(C) with expertise in health information security;

“(D) with expertise in health information privacy; and

“(E) with experience in healthcare quality and patient safety, including those with experience in utilizing health information technology to improve healthcare quality and patient safety.

“(f) IN GENERAL.—The Standards Working Group shall—

“(1) review existing standards (including content, communication, and security standards) for the electronic exchange of health information, including such standards deemed adopted under subsection (c);

“(2) identify deficiencies and omissions in such existing standards;

“(3) identity duplications and omissions in existing standards, and recommend modifications to such standards; and

“(4) submit a report to the Secretary recommending for adoption by such Secretary and private entities—

“(i) modifications to the standards deemed adopted under subsection (c); and

“(ii) any additional standards reviewed pursuant to this paragraph.

“(2) OCCASIONAL REVIEW.—Beginning 1 year after the date of enactment of this title, and on an ongoing basis thereafter, the Standards Working Group shall—

“(A) review existing standards (including content, communication, and security standards) for the electronic exchange of health information, including such standards adopted by the Secretary under subsection (c) and (e);

“(B) identity deficiencies and omissions in such existing standards;

“(C) identity duplications and omissions in existing standards, and recommend modifications to such standards as necessary; and

“(D) submit reports to the Secretary recommending for adoption by such Secretary and private entities—

“(i) modifications to any existing standards; and

“(ii) any additional standards reviewed pursuant to this paragraph.

“(3) LIMITATION.—The standards described under this subsection shall not include any standards developed pursuant the Health Insurance Portability and Accountability Act of 1996.

“(c) ADOPTION BY SECRETARY.—Not later than 1 year after the receipt of a report from the Standards Working Group pursuant to paragraph (1)(D) or (2)(D) of subsection (d), the Secretary shall review and provide for the adoption by the Federal Government of any modification or standard recommended in such report.

“(d) VOLUNTARY ADOPTION.—Any standards adopted by the Secretary under this section shall be voluntary for private entities.

“(e) IMPLEMENTATION.—

“(1) IN GENERAL.—The Secretary, in consultation with the National Coordinator and the Director of the National Institute of Standards and Technology, shall develop criteria to ensure uniform and consistent implementation of any standards for the electronic exchange of health information voluntarily adopted by private entities in technical conformance with such standards adopted under this title.

“(2) IMPLEMENTATION ASSISTANCE.—The Secretary may recognize a private entity or entities to assist private entities in the implementation of the standards adopted under this title.

“SEC. 2905. AUTHORITY FOR COORDINATION AND SPENDING.

“(a) STUDY AND GRANT PROGRAMS RELATED TO STATE HEALTH INFORMATION LAWS AND PRACTICES.—

“(1) IN GENERAL.—The Secretary acting through the National Coordinator—

“(I) shall direct and coordinate—

“(A) Federal spending related to the development, adoption, and implementation of standards for the electronic exchange of health information; and

“(B) the adoption of the recommendations submitted to such Secretary pursuant to such Standards Working Group established under section 2903; and

“(2) may utilize the entities recognized under section 2904 to provide assistance and certification related to the implementation by the Federal Government of the standards adopted by the Secretary under this title.

“(b) LIMITATION.—

“(1) IN GENERAL.—Notwithstanding any other provision of law, no Federal agency shall expend Federal funds for the purchase of hardware, software, or support services for the purpose of implementing a standard related to the electronic exchange of health information that is not a standard adopted by the Secretary under section 2903.

“(2) EFFECTIVE DATE.—The limitation under paragraph (1) shall take effect not later than 1 year after the adoption by the Secretary of such standards under section 2903.

“SEC. 102. ENCOURAGING SECURE EXCHANGE OF HEALTH INFORMATION.

“(a) STUDY AND GRANT PROGRAMS RELATED TO STATE HEALTH INFORMATION LAWS AND PRACTICES.—

“(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this Act as the ‘Secretary’) shall carry out, or contract with a private entity to carry out, a study that examines—

“S36755
(i) the variation among State laws and practices that relate to the privacy, confidentiality, and security of health information;
(ii) how such variation among State laws and practices may impact the electronic exchange of health information (as defined in section 2901 of the Public Health Service Act (as provided by section 101)—
   (I) among the States;
   (II) between the States and the Federal Government; and
   (III) among private entities; and
(iii) how such laws and practices may be harmonized to permit the secure electronic exchange of health information.

(B) RECOMMENDATIONS.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to Congress a report that—
   (i) describes the results of the study carried out under subparagraph (A); and
   (ii) makes recommendations based on the results of such study.

(2) SECURE EXCHANGE OF HEALTH INFORMATION; INCENTIVE GRANTS.

(a) IN GENERAL.—The Secretary may make grants to carry out programs under which such States cooperate with other States to develop and implement State policies that will facilitate the secure electronic exchange of health information utilizing the standards adopted under section 2903;

(1) among the States;

(2) between the States and the Federal Government; and

(3) among private entities.

(b) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to States that provide assurance that any funding awarded under such a grant shall be used to harmonize privacy laws and practices between the States, the States and the Federal Government, and among private entities related to the privacy, confidentiality, and security of health information.

(c) DISSEMINATION OF INFORMATION.—The Secretary shall disseminate information regarding the efficacy of efforts of a recipient of a grant under this section.

(d) COSTS OF ASSURANCE.—The Secretary may provide technical assistance to recipients of a grant under this section.

(e) AUTHORIZATION OF APPROPRIATIONS.—For carrying out the programs under subsection (a), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2006 through 2010.

(B) STUDY AND GRANT PROGRAMS RELATED TO STATE LICENSURE LAWS.—

(1) STUDY OF STATE LICENSURE LAWS.—

(A) IN GENERAL.—The Secretary shall carry out a study to determine whether a private entity to carry out, a study that examines—

(i) the variation among State laws that relate to the licensure, registration, and certification of medical professionals; and

(ii) how such variation among State laws impacts the secure electronic exchange of health information (as defined in section 2901 of the Public Health Service Act) (as provided by section 101)—

   (I) among the States; and
   (II) between the States and the Federal Government;

(B) REPORT AND RECOMMENDATIONS.—Not later than 1 year after the date of enactment of this Act, the Secretary shall publish a report that—

   (i) describes the results of the study carried out under subparagraph (A); and
   (ii) makes recommendations to States regarding the harmonization of State laws based on the results of such study.

(2) REAUTHORIZATION OF INCENTIVE GRANTS.—Title XXIX of the Public Health Service Act (42 U.S.C. 254c–18(b)) is amended by striking “2002 through 2006” and inserting “2006 through 2010”.

(3) HIPAA APPLICATION TO ELECTRONIC HEALTH INFORMATION.—Title XXIX of the Public Health Service Act (as added by section 101) is further amended by adding at the end the following:

   SEC. 2907. APPLICABILITY OF PRIVACY AND SECURITY REQUIREMENTS.

   "(a) IN GENERAL.—The regulations promulgated by the Secretary under part C of title XI of the Social Security Act and sections 261, 262, 263, and 264 of the Health Insurance Portability and Accountability Act of 1996 with respect to the privacy, confidentiality, and security of health information shall—

   (1) apply to any health information stored or transmitted in an electronic format as of the date of enactment of this title; and

   (2) apply to the implementation of standards, programs, and activities under this title."

   (b) STUDY AND REPORT.—

   (1) STUDY.—Not later than 2 years after the date of enactment of this Act, the Secretary shall carry out, or contract with a private entity to carry out, a study that examines the integration of the standards adopted under the amendments made by this Act with the standards adopted under the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191).

   (2) PLAN; REPORT.—

   (A) PLAN.—Not later than 3 years after the date of enactment of this Act, the Secretary shall, based on the results of the study carried out under section (a)(1), in such manner as determined by the Secretary, request the integration of the standards described under such paragraph and submit a report to Congress describing such plan.

   (B) PERIODIC REPORTS.—The Secretary shall submit periodic reports to Congress that describe the progress of the integration described under paragraph (a).

   (C) USE OF FUNDS.—

   (1) IN GENERAL.—The Secretary shall carry out the purposes under subsection (a) by using in such manner as the Secretary determines to be appropriate any funds made available under this section.

   (2) PRIORITY.—Of the funds made available under this section, the Secretary shall prioritize grants under subsection (a) to States that demonstrate that one of its principal missions or purposes is to use information technology to improve healthcare quality and efficiency.

   (3) GRANTS TO PROVIDERS.—

   (A) IN GENERAL.—Grants under subsection (a) shall be provided to eligible providers for the following:

   (i) to implement the electronic exchange of health information; and

   (ii) to implement the electronic exchange of health information in a manner that includes the use of health information technology standards adopted by the Secretary under section 2903;

   (3) R EAUTHORIZATION OF INCENTIVE GRANTS

   SEC. 2908. GRANTS FOR THE IMPLEMENTATION OF REGIONAL OR LOCAL HEALTH INFORMATION TECHNOLOGY PLANS.

   (a) IN GENERAL.—The Secretary, in consultation with the National Coordinator, may award grants to eligible entities for the implementation of local or regional health information plans to improve healthcare quality and efficiency through the electronic exchange of health information pursuant to the standards, protocols, and other requirements adopted by the Secretary under sections 2903 and 2910.

   (b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a) an entity shall—

   (1) demonstrate financial need to the Secretary;

   (2) demonstrate that one of its principal missions or purposes is to use information technology to improve healthcare quality and efficiency;

   (3) adopt bylaws, memoranda of understanding, and other documents that demonstrate that the governance structure and decisionmaking processes of such entity allow for participation on an ongoing basis by multiple stakeholders within a community, including—

   (A) physicians (as defined in section 1861(m) of the Social Security Act), including physicians that provide services to low income and underserved populations;

   (B) hospitals (including hospitals that provide services to low income and underserved populations);

   (C) group health plans or other health insurance issuers;

   (D) health centers (as defined in section 330(b)(1) and Federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act);

   (E) health clinics (as defined in section 1861(aa) of the Social Security Act);

   (F) consumer organizations; and

   (G) employers; and

   (H) any other healthcare providers or other entities, as determined appropriate by the Secretary;

   (4) adopt nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory participation in the health information plan by all stakeholders;

   (5) adopt the national health information technology standards adopted by the Secretary under section 2903;

   (6) facilitate the electronic exchange of health information within the local or regional area and among local and regional areas; and

   (7) prepare and submit to the Secretary an application in accordance with subsection (c); and

   (8) agree to provide matching funds in accordance with subsection (e).

   (c) APPLICATION.—

   (1) IN GENERAL.—To be eligible to receive a grant under subsection (a), an entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

   (2) REQUIRED INFORMATION.—At a minimum, an application submitted under this subsection shall include—

   (A) clearly identified short-term and long-term objectives of the regional or local health information plan;

   (B) a technology plan that complies with the standards adopted under section 2903 and that includes a descriptive and reasoned estimation of the costs of the plan including the cost of software, training, and consulting services necessary to implement the regional or local health information plan;

   (3) STRATEGY.—A strategy that includes initiatives to improve healthcare quality and efficiency, including the use of healthcare quality measures adopted under section 2910;

   (4) a plan that describes provisions to encourage the implementation of the electronic exchange of health information by all physicians, including single physician practices and small physician groups participating in the health information plan;

   (5) a plan to ensure the privacy and security of personal health information that is consistent with Federal and State law;

   (F) a governance plan that defines the manner in which the stakeholders shall jointly make policy and operational decisions on an ongoing basis; and

   (G) a financial or business plan that describes—

   (i) the sustainability of the plan;

   (ii) the financial costs and benefits of the plan; and

   (iii) the entities to which such costs and benefits will accrue.

   (d) U SE OF FUNDS.—

   (1) IN GENERAL.—The Secretary shall carry out the purposes under subsection (a) by using in such manner as the Secretary determines to be appropriate any funds made available under this section.
to an entity or individual for developing, implementing, operating, or facilitating the electronic exchange of health information (as defined in section 2901 of the Public Health Service Act) that is primarily designed to promote the electronic exchange of health information.

(2) Determination of amount contributed.—Federal contributions required under paragraph (1) may be in cash or in kind, fairly evaluated, including equipment, technology, or services. Amounts provided by the Federal Government, or services sisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

(1) Authorization of Appropriations.—

(1) In general.—There is authorized to be appropriated to carry out this section, $125,000,000 for each of fiscal years 2006 through 2010.

(2) Availability.—Amounts appropriated under paragraph (1) shall remain available for obligations incurred through the end of fiscal year 2010.

SEC. 2909. REPORTS.

Not later than 1 year after the date on which the first grant is awarded under section 2908, and annually thereafter during the grant period, an entity that receives a grant under such section shall submit to the Secretary, acting through the National Coordinator for Health Information Technology, a report on the grant that describes the following:

(1) a description of the financial costs and benefits of the project involved and of the entities to which such costs and benefits accrue;

(2) an analysis of the impact of the project on healthcare quality and safety;

(3) a description of any reduction in duplicative or unnecessary care as a result of the project involved; and

(4) other information as required by the Secretary.

SEC. 2910. SUCCESSOR PROVISIONS TO SECTION 2904.

The amendments made by this section shall be effective without regard to whether a measure of quality is primarily designed to promote the electronic exchange of health information (as defined in section 2901 of the Public Health Service Act). The amendments made by this section shall be treated as amendments to, and not as additions to, any other provision of law relating to electronic health records.

SEC. 3001. MEASURES OF QUALITY AND USE OF HEALTHCARE QUALITY MEASURES.

(a) In general.—

(1) Collaboration.—The Secretary, the Secretary of Defense, the Secretary of Veterans Affairs, and any other head of relevant Federal agencies as determined appropriate by the President, acting through the Secretary (in this section the 'Secretary'), shall adopt, on a ongoing basis, uniform healthcare quality measures to assess the effectiveness, timeliness, patient safety, patient-centeredness, efficiency, and safety of care delivered by healthcare providers across Federal healthcare programs, including those in titles XVIII, XIX, and XXI of the Social Security Act.

(2) Review of measures adopted.—The Secretary shall conduct an ongoing review of the measures adopted under paragraph (1).

(3) Existing activities—Notwithstanding any other provision of law, the measures and reporting activities adopted under subsection (a) shall replace, to the extent practicable and appropriate, any duplicative or redundant existing measurement and reporting activities currently utilized by Federal healthcare programs, including those in titles XVIII, XIX, and XXI of the Social Security Act.

(b) Priority measures.—

(1) In general.—In determining the measures to be adopted under subsection (a), and the timing of any such adoption, the Secretary shall give priority to:

(A) measures with the greatest potential impact for improving the quality and efficiency of care provided under Federal programs;

(B) measures that may be rapidly implemented by group health plans, health insurance issuers, physicians, hospitals, nursing homes, long-term care providers, and other providers; and

(C) measures which may inform healthcare decisions made by consumers and payers.

(2) National quality forum measures; quality of care indicators.—To the extent determined feasible and appropriate by the Secretary, the Secretary shall adopt:

(A) measures endorsed by the National Quality Forum, subject to compliance with the amendments made by the National Technology Transfer and Advancement Act of 1995; and

(B) indicators relating to the quality of care data submitted to the Secretary by hospitals under section 1886(b)(3)(B)(iv)(II) of the Social Security Act.

(c) Collaboration with private entities.—

(1) In general.—The Secretary shall establish collaborative agreements with private entities, including group health plans...
and health insurance issuers, providers, purchasers, consumer organizations, and entities receiving a grant under section 2908, to—

(A) encourage the use of the healthcare quality services evaluated by the Secretary under this section; and

(B) foster uniformity between the healthcare quality measures utilized in Federal programs and private entities.

(2) USE OF MEASURES.—The measures adopted by the Secretaries under this section may be applied in one or more disease areas and across public health officials, researchers, and other appropriate individuals and entities, the Secretaries and other relevant agencies shall provide for the aggregation, analysis, and dissemination of quality measures collected under this section. Nothing in this section shall be construed as modifying the privacy standards under the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

(e) EVALUATIONS.—

(1) USE OF EVALUATIONS OF USE.—The Secretary shall ensure the ongoing evaluation of the use of the healthcare quality measures adopted under this section.

(2) REPORT.—

(A) EVALUATION.—The Secretary shall, directly or indirectly through a contract with another entity, conduct an evaluation of the collaborative efforts of the Secretaries to adopt uniform healthcare quality measures and reporting requirements for federally supported healthcare delivery programs as required by this section.

(B) REPORT.—Not later than 2 years after the date of enactment of this title, the Secretary shall submit a report to the appropriate committees of Congress concerning the results of the evaluation under subparagraph (A).

SEC. 302. VALUE-BASED PURCHASING PROGRAMS: SENSE OF THE SENATE.

(a) MEDICARE VALUE BASED PURCHASING PILOT PROGRAM.—

(1) IN GENERAL.—The Secretary shall establish, under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), a value-based purchasing pilot program based on the reporting of quality measures for services pursuant to that adopted in section 2901 of the Public Health Service Act (as added by section 301) and the overall improvement of healthcare quality through the use of electronic exchange of health information pursuant to the standards adopted under section 2903 of the Public Health Service Act (as added by section 101). The Secretary shall ensure that the descriptions under items (aa), (bb), and (cc) of clause (I) are reasonable, accurate, and based on generally accepted uniform methodologies, including that the steps described in subclause (I)(cc) will be adequate to avoid violating the limitation described in subparagraph (B).

(b) APPLICATION OF LIMITATION.—If the Secretary determines that the provisions of this subsection will result in the limitation described in subparagraph (B) being violated in any year, the Secretary shall take appropriate steps to reduce spending that is occurring by reason of such provisions, including through reducing the scope, site, and duration of the pilot project.

(c) AUTHORITY.—The Secretary shall require such steps to be taken as are necessary to ensure that the limitation described in subparagraph (B) is not violated in any year.

(b) SENSE OF THE SENATE REGARDING PHYSICIAN PRACTITIONER.—It is the sense of the Senate that modifications to the Medicare fee schedule for physicians’ services under section 1848 of the Social Security Act (42 U.S.C. 1395vv) that would otherwise prevent a State from enacting, implementing, or establishing uniform healthcare quality measures pursuant to the provisions of this section shall be construed as modifying the Social Security Act.

(c) MEDICAID VALUE BASED PURCHASING PROGRAMS.—

(1) IN GENERAL.—The Secretary shall authorize waivers under section 1115 of the Social Security Act (42 U.S.C. 1396a) for States to establish value based purchasing programs for State medicaid programs established under title XIX of such Act (42 U.S.C. 1396 et seq.). Such programs shall provide for the aggregation, analysis, and dissemination of quality measures pursuant to the provisions of this section.

(2) WAIVER.—In authorizing such waivers, the Secretary shall waive any provisions of title XI or XIX of the Social Security Act that would otherwise prevent a State from establishing a value based purchasing program in accordance with paragraph (1).

(d) QUALITY INFORMATION SHARING.—

(1) REVIEW OF MEDICARE CLAIMS DATA.—

(A) PROCEDURES.—In order to improve the quality and efficiency of items and services furnished to medicare beneficiaries under title XVIII of the Social Security Act, the Secretary shall ensure that the most recent claims data submitted under such title with respect to items and services furnished or ordered by physicians.

(B) REPORT.—Not later than April 1 of each year following the year in which the pilot program under paragraph (1) is implemented, the Secretary shall submit a report to Congress and the Comptroller General of the United States that includes—

(I) a detailed description of—

(aa) the total amount spent from the Trust Funds (amounts expended as a result of the provisions of this subsection) during the previous year compared to the total amount that would have been expended from the Trust Funds in a year if this subsection had not been enacted;

(bb) the projections of the total amount that will be expended from the Trust Funds (amounts expended as a result of the provisions of this subsection) during the year in which the report is submitted compared to the total amount that would have been expended from the Trust Funds during the year if this subsection had not been enacted; and

(cc) specify the steps (if any) that the Secretary will take pursuant to subparagraph (D) to ensure that the limitation described in subparagraph (B) will not be violated; and

(ii) a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the descriptions under items (aa), (bb), and (cc) of clause (I) are reasonable, accurate, and based on generally accepted uniform methodologies, including that the steps described in subclause (I)(cc) will be adequate to avoid violating the limitation described in subparagraph (B).

(2) USE OF MOST RECENT MEDICARE CLAIMS DATA.—In conducting the review under subparagraph (A), the Secretary shall use the most recent claims data that is available to the Secretary.

(3) REPORTING DATE.—The amendment made by this section shall apply to contracts entered into on or after the date of enactment of this Act.

By Mr. BOND.

S. 1263. A bill to amend the Small Business Act to establish eligibility requirements for business concerns to receive awards under the Small Business Innovation Research Program; to the Committee on Small Business and Entrepreneurship.

Mr. BOND. Mr. President, the United States biotechnology industry is the world leader in innovation. This is due, in large part, to the Federal Government’s partnership with the private sector to foster growth and commercialization in the hope that one day we will discover and develop medical needs such as cystic fibrosis, heart disease, various cancers, multiple sclerosis, and AIDS.

However, the industry was dealt a major setback last year when the Small Business Administration—SBA—determined that venture-backed bio-technology companies can no longer