The Department of Education applies provisions concerning change of institutional ownership to nonprofit institutions, despite clear expression of contrary congressional intent and 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 intended 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. OBAMA):

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 State of New York. 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, typically stored in the basements 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 in nearly every aspect of the clinical setting, the delivery of medicine. From very compact bedside monitors to these massive MRI scanners we have today, computers power 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 or confused to a 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 emptyhanded, with no notification of allergies or past 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 quality 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 can go to an ATM virtually 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 national 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 a small efficiency improvement 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 leader 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, is not 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

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

The Government should not impose these 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 electronic health records for all of their clients.

The Veterans' Administration already 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 can know what needs to be done for these brave young men and women.

Secondly, we believe our legislation should work to reduce barriers and facilitate the electronic exchange of health information among providers in a secure and private way to improve health care quality and meet community needs. When communities come together, as is beginning to happen all over the country, the Federal Government 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.

Finally, 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 enormous and unpardonable disparities in the quality of care. Health IT will be a tool to help our dedicated health care professionals improve care, and efficiently, so that they spend more time at the bedside, more time at the office visit, and less on paperwork.

Through this legislation, 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 Government 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 concrete benefits to them as individuals and to their families?

First, it will reduce waste and inefficiency in the system. It only makes sense that fragmented systems, with no interconnectivity at all, have inherent inefficiencies and waste. That is moved aside. That has a very direct impact 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 application of technology, we can move those 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-driven 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 empowerment to make that choice.

They will protect patient privacy and promote the secure exchange of lifesaving 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 advancements, harmonizing and integrating 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 potential of medical information technology for all Americans.

Mrs. CLINTON. I am delighted to be working on this very important national initiative with the majority leader because we are at a pivotal moment. Pockets of innovation and investment are developing all over the country. In my State, places like Rochester, NY, and in the majority leader's State, the Tri-Cities region of Tennessee, health care providers, employers and community groups are beginning the process of building a health information technology network. That is a positive first step, but it could be either a last step or a misstep because to truly achieve the promise of health information technology, we must ensure that these efforts do not become silos. In other words, there is one system for every hospital, one system for every clinical practice. They cannot talk to each other. So a person goes to one doctor. Their doctor is in New York, but they travel to Tennessee to visit friends, they are in an accident, and nobody knows how to get the information that will give them the best possible treatment.

So if we do this right, this comprehensive legislation will create a health information technology framework that improves quality, protects patient privacy and ensures interoperability through the adoption of health IT standards and quality measures.

We are marrying technology and quality to create a seamless, efficient health care system for the 21st century. I thank the majority leader, who has brought so much interest and expertise to this, for being a leader and making this happen in the next 18 months.

Mr. FRIST. I thank my colleague in this endeavor. As mentioned earlier, we began working on the information technology aspects of health care about a year ago and published our first op-ed together about July of last year.

In closing, this is not going to be an easy process. I look back at the technology in my past in medicine for 20 years, but then also in my dad's practice; he practiced medicine for 55 years. I remember he had one of the very earliest electrocardiogram, EKG, machines in the State of Tennessee. At that time—because there were so few machines and so few cardiologists—he would take referrals from all over the State of Tennessee. The machine itself was bigger than the desk before me, at the time.

What would happen then is, if there was a machine in a little rural community 100 miles away from Nashville, the machine there would take a piece of paper, they would run it through, they would send it by mail. It would take 2 days to get to Nashville. Dad would read it and send it back. Four days later, that doctor would be able to read that EKG.

Then, when I was about 9 or 10 years of age—because their bedroom was right around the corner from mine—I remember so well when he installed a telephone to put another big box there to have the first in Tennessee again of a machine—and it was amazing at the time—one could transmit these EKGs electronically over the telephone wire and have it interpreted at the bedside. He would keep it there because people, of course, have heart attacks in the middle of the night. Then it would take probably about 30 or 40 minutes to get the result back.

Of course, today we are at a point where with a little tiny machine, an EKG machine, we can get an instantaneous readout not just of the paper and of the EKG but the result actually read by the box.

I have been able to see huge progress in my own life and watching my dad's practice and my practice. Now we need to see all of that sort of progress condensed, applied not just to the technology but to the collection of information, the promotion of electronic health records, and the appropriate sharing of that information which is privacy protected. That is the sort of progress we are going to see. We are going to see it come alive on the Senate floor and with the House and work

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 introduce does present a comprehensive approach of medical information and the use of medical information as we address our health care challenges. It provides that important backbone and critical building block for a better, a stronger, and a more responsive health care system 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. OBAMA. Mr. President, I am proud to join Senators FRIST and CLINTON in introducing the Health Technology to Enhance Quality Act of 2005.

Our national health care system is in crisis. Forty-five million Americans are uninsured, 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 diabetes or AIDS that could have been prevented or 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 century. 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 information about patients is not shared between 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 effectively and efficiently to make patients 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 embracing 21st century technology is not just about reducing errors and improving the quality of medical care. It is also about cost.

We spend nearly $1.5 trillion a year on health care in America. But a quarter of that money—one out of every four dollars—is spent on non-medical costs—most of it on bills and paperwork. Every transaction you make at a bank now costs them less than a penny. Yet, because we have not updated technology in the rest of the health care industry, 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 standards to ensure interoperability of health information systems. The legislation codifies the Office of National Coordinator for Information Technology and establishes standards for the electronic exchange of health information. The bill also provides grant funding to support development of health information technology infrastructure as well as measurement of the quality of care provided to patients.

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. 1262

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 TECHNOLOGY STANDARDS ADOPTION AND INFRASTRUCTURE DEVELOPMENT

SEC. 101. ESTABLISHMENT OF NATIONAL COORDINATOR; RECOMMENDATION, ADOPTION, AND IMPLEMENTATION OF HEALTH INFORMATION 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 hospital, skilled nursing facility, home health entity, healthcare clinic, community health center, group practice (as defined in section 1877(h)(4) of the Social Security Act), a physician (as defined in section 1861(r)(1) of the Social Security Act), a pharmacist, a pharmacy, a laboratory, and any other category of facility or clinician determined appropriate by the Secretary.

''(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, the provision of healthcare to an individual, or the past, present, or future payment for the provision of healthcare to an individual.

''(4) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given that term in section 2791.

''(5) LABORATORY.—The term 'laboratory' has the meaning given that term in section 353.

''(6) PHARMACIST.—The term 'pharmacist' has the meaning given that term in section 804 of the Federal Food, Drug, and Cosmetic Act.

''SEC. 2902. OFFICE OF THE NATIONAL COORDINATOR OF HEALTH INFORMATION TECHNOLOGY.

''(a) OFFICE OF NATIONAL HEALTH INFORMATION TECHNOLOGY.—There is established within the Office of the Secretary an Office of the National Coordinator of Health Information Technology (referred to in this section as the 'Office'). The Office shall be headed by a National Coordinator who shall be appointed by the President in consultation with the Secretary and shall report directly to the Secretary.

''(b) PURPOSE.—It shall be the purpose of the Office to carry out programs and activities to develop a nationwide interoperable health information technology infrastructure that—

''(1) improves healthcare quality, reduces medical errors, and advances the delivery of patient-centered medical care;

''(2) reduces healthcare costs resulting from inefficiency, medical errors, inappropriate care, and incomplete information;

''(3) ensures that appropriate information to help guide medical decisions is available at the time and place of care;

''(4) promotes a more effective marketplace, greater competition, and increased choice through the wider availability of accurate information on healthcare costs, quality, and outcomes;

''(5) improves the coordination of care and information among hospitals, laboratories, physician offices, and other entities through an effective infrastructure for the secure and authorized exchange of healthcare information;

''(6) improves public health reporting and facilitates the early identification and rapid response to public health threats and emergencies, including bioterror events and infectious disease outbreaks;

''(7) facilitates health research; and

''(8) ensures that patients' health information is secure and protected.

''(c) DUTIES OF NATIONAL COORDINATOR.—

''(1) IN GENERAL.—The National Coordinator shall—

''(A) facilitate the adoption of a national system for the electronic exchange of health information;

''(B) serve as the principal advisor to the Secretary on the development, application, and use of health information technology, and coordinate and oversee the health information technology programs of the Department;

''(C) ensure the adoption and implementation of standards for the electronic exchange of health information, including coordinating the activities of the Standards Working Group under section 2903;

''(D) carry out activities related to the electronic exchange of health information that reduce cost and improve healthcare quality;

''(E) ensure that health information technology policy and programs of the Department are coordinated with those of relevant executive branch agencies (including Federal commissions) with a goal of avoiding duplication of efforts and of helping to ensure that each agency undertakes health information technology activities primarily within the areas of its greatest expertise and technical capability;

''(F) to the extent permitted by law, coordinate outreach and consultation by the relevant executive branch agencies (including Federal commissions) with public and

private parties of interest, including consumers, payers, employers, hospitals and other healthcare providers, physicians, community health centers, laboratories, vendors and other stakeholders;

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

''(H) submit 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) be in addition to any other staff of the Department employed by the National Coordinator.

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

''(e) AUTHORIZATION OF APPROPRIATIONS.—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 RECOMMENDATION, 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, including 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 group 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;

''(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) of consumer and patient organizations;

''(G) of employers;

''(H) with experience in data exchange; and

''(I) with experience in developing health information technology standards and new health information technology; and

''(6) other representatives as determined appropriate by the National Coordinator in consultation with the Secretary.

''(c) STANDARDS DEEMED ADOPTED.—On the date of enactment of this title, the Secretary and the Standards Working Group shall deem as adopted, for use by the Secretary and private entities, the standards adopted by the Consolidated Health Informatics Initiative prior to such date of enactment.

''(d) DUTIES.—

''(1) FIRST YEAR REVIEW.—Not later than 1 year after the date of enactment of this title, 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 deemed adopted under subsection (c);

''(B) identify 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 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) ONGOING 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 subsections (c) and (e);

''(B) identify 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.

''(e) ADOPTION BY SECRETARY.—Not later than 1 year after the receipt of a report from the Standards Working Group under 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.

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

''(g) APPLICATION OF FACA.—

''(1) IN GENERAL.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the Standards Working Group established under this section.

''(2) LIMITATION.—Notwithstanding paragraph (1), the 2-year termination date under section 14 of the Federal Advisory Committee Act shall not apply to the Standards Working Group.

''SEC. 2904. IMPLEMENTATION AND CERTIFICATION OF HEALTH INFORMATION STANDARDS.

''(a) 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.

''(b) CERTIFICATION.—

''(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 and certify that hardware, software, and support services that claim to be in compliance with any standard for the electronic exchange of health information adopted under this title have established and maintain such compliance in technical conformance with such standard.

''(2) CERTIFICATION ASSISTANCE.—The Secretary may recognize a private entity or entities to assist in the certification described under paragraph (1).

''(c) DELEGATION AUTHORITY.—The Secretary may delegate the development of the criteria under subsection (a) and (b) to a private entity.

''SEC. 2905. AUTHORITY FOR COORDINATION AND SPENDING.

''(a) IN GENERAL.—The Secretary acting through the National Coordinator—

''(1) 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 by the Standards Working Group established under section 2903; and

''(2) may utilize the entities recognized under section 2904 to assist in implementation 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) STUDY OF STATE HEALTH INFORMATION LAWS AND PRACTICES.—

(A) 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—

(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 added 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) REPORT AND 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.—Title XXIX of the Public Health Service Act (as added by section 101) is amended by adding at the end the following:

''SEC. 2906. SECURE EXCHANGE OF HEALTH INFORMATION; INCENTIVE GRANTS.

''(a) IN GENERAL.—The Secretary may make grants to States 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) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to recipients of a grant under this section.

''(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out 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, or contract with 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 added 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 REGARDING TELEMEDICINE.—Section 330L(b) 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 and amended by subsection (a)) is further amended by adding at the end the following:

''SEC. 2907. APPLICABILITY OF PRIVACY AND SECURITY REGULATIONS.

''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.''.

(c) 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 paragraph (1), develop a plan for 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 subparagraph (A).

TITLE II—FACILITATING THE ADOPTION AND IMPLEMENTATION OF INTEROPERABLE ELECTRONIC HEALTH INFORMATION

SEC. 201. GRANTS FOR THE IMPLEMENTATION OF REGIONAL OR LOCAL HEALTH INFORMATION TECHNOLOGY PLANS.

Title XXIX of the Public Health Service Act (as amended by section 102) is further amended by adding at the end the following:

''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 competitive grants to eligible entities to implement regional or local 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, or other charter 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(r)(1) 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)) and Federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act);

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

''(F) consumer organizations;

''(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;

''(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 estimate of costs of the hardware, software, training, and consulting services necessary to implement the regional or local health information plan;

''(C) a strategy that includes initiatives to improve healthcare quality and efficiency, including the use of healthcare quality measures adopted under section 2910;

''(D) 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;

''(E) 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) USE OF FUNDS.—Amounts received under a grant under subsection (a) shall be used to establish and implement a regional

or local health information plan in accordance with this section.

''(e) MATCHING REQUIREMENT.—

''(1) IN GENERAL.—The Secretary may not make a grant under this section to an entity unless the entity agrees that, with respect to the costs to be incurred by the entity in carrying out the infrastructure program for which the grant was awarded, the entity will make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount equal to not less than 50 percent of such costs ($1 for each $2 of Federal funds provided under the grant).

''(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-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 assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

''(f) 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 obligation until expended.

''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, a report on the activities carried out under the grant involved. Each such report shall include—

''(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. 202. EXCEPTION FOR THE PROVISION OF PERMITTED SUPPORT.

(a) EXEMPTION FROM CRIMINAL PENALTIES.—Section 1128B(b) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)) is amended—

(1) in paragraph (3)—

(A) in subparagraph (G), by striking ''and'' at the end;

(B) in subparagraph (H), as added by section 237(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2213)—

(i) by moving such subparagraph 2 ems to the left; and

(ii) by striking the period at the end and inserting a semicolon;

(C) by redesignating subparagraph (H), as added by section 431(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2287), as subparagraph (I);

(D) in subparagraph (I), as so redesignated—

(i) by moving such subparagraph 2 ems to the left; and

(ii) by striking the period at the end and inserting ''; and''; and

(E) by adding at the end the following new:

''(J) subject to paragraph (4), the provision, with or without charge, of any permitted support (as defined in paragraph (4)(A) and subject to the conditions in paragraph (4)(B)) 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), so long as such support is primarily designed to promote the electronic exchange of health information.''; and

(2) by adding at the end the following:

''(4) PERMITTED SUPPORT.—

''(A) DEFINITION OF PERMITTED SUPPORT.—In this section, the term 'permitted support' means the provision of, or funding used exclusively to provide or pay for, any equipment, item, information, right, license, intellectual property, software, or service, regardless of whether any such support may have utility or value to the recipient for any purpose beyond the exchange of health information (as defined in section 2901 of the Public Health Service Act).

''(B) CONDITIONS ON PERMITTED SUPPORT.—Paragraph (3)(J) shall not apply unless the following conditions are met:

''(i) The provision of permitted support is not conditioned on the recipient of such support making any referral to, or generating any business for, any entity or individual for which any Federal health care program provides reimbursement.

''(ii) The permitted support complies with the standards for the electronic exchange of health information adopted by the Secretary under section 2903 of the Public Health Service Act.

''(iii) The entity or network receiving permitted support is able to document that such support is used by the entity or the network for the electronic exchange of health information in accordance with the standards adopted by the Secretary under section 2903 of the Public Health Service Act.''.

(b) EXEMPTION FROM LIMITATION ON CERTAIN PHYSICIAN REFERRALS.—Section 1877(e) of the Social Security Act (42 U.S.C. 1395nn(e)) is amended by adding at the end the following:

''(9) PERMITTED SUPPORT.—The provision of permitted support (as described in section 1128B(b)(3)(J)).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to permitted support provided on or after the date of enactment of this Act.

SEC. 203. GROUP PURCHASING.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary shall establish a safe harbor for group purchasing of hardware, software, and support services for the electronic exchange of health information in compliance with section 2903 of the Public Health Service Act (as added by section 101).

(b) CONDITIONS.—In establishing the safe harbor under subsection (a), the Secretary shall establish conditions on such safe harbor consistent with the purposes of—

(1) improving healthcare quality;

(2) reducing medical errors;

(3) reducing healthcare costs;

(4) improving the coordination of care;

(5) streamlining administrative processes; and

(6) promoting transparency and competition.

SEC. 204. PERMISSIBLE ARRANGEMENTS.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act and notwithstanding any other provision of law, the Secretary shall establish guidelines in compliance with section 2903 of the Public Health Service Act that permit certain arrangements between group health plans and health insurance issuers (as defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91)) and between healthcare providers (as defined in section 2901 of such Act, as added by section 101) in accordance with subsection (b).

(b) CONDITIONS.—In establishing the guidelines under subsection (a), the Secretary shall establish conditions on such arrangements consistent with the purposes of—

(1) improving healthcare quality;

(2) reducing medical errors;

(3) reducing healthcare costs;

(4) improving the coordination of care;

(5) streamlining administrative processes; and

(6) promoting transparency and competition.

TITLE III—ADOPTION, IMPLEMENTATION, AND USE OF HEALTHCARE QUALITY MEASURES

SEC. 301. STANDARDIZED MEASURES.

Title XXIX of the Public Health Service Act (as amended by section 201) is further amended by adding at the end the following:

''SEC. 2910. COLLABORATIVE PROCESS FOR THE DEVELOPMENT, RECOMMENDATION, AND ADOPTION OF STANDARDIZED MEASURES OF QUALITY HEALTHCARE.

''(a) IN GENERAL.—

''(1) COLLABORATION.—The Secretary, the Secretary of Defense, the Secretary of Veterans Affairs, and any other heads of relevant Federal agencies as determined appropriate by the President, (referred to in this section as the 'Secretaries') shall adopt, on an ongoing basis, uniform healthcare quality measures to assess the effectiveness, timeliness, patient self-management, 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 Secretaries 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 described in this subsection 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 Secretaries 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 patients.

''(2) NATIONAL QUALITY FORUM MEASURES; QUALITY OF CARE INDICATORS.—To the extent determined feasible and appropriate by the Secretaries, the Secretaries 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)(vii)(II) of the Social Security Act.

''(c) COLLABORATION WITH PRIVATE ENTITIES.—

''(1) IN GENERAL.—The Secretaries may 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 measures adopted 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 apply in one or more disease areas and across delivery settings, in order to improve the quality of care provided or delivered by private entities.

''(d) COMPARATIVE QUALITY REPORTS.—Beginning on January 1, 2008, in order to make comparative quality information available to healthcare consumers, health professionals, 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) ONGOING EVALUATIONS OF USE.—The Secretary shall ensure the ongoing evaluation of the use of the healthcare quality measures adopted under this section.

''(2) EVALUATION AND 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 under 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 pursuant to those adopted in section 2910 of the Public Health Service Act (as added by section 301) and the overall improvement of healthcare quality through the use of the electronic exchange of health information by entities (including Federally qualified health centers, as defined in section 1861(aa)(4) of the Social Security Act (42 U.S.C. 1395x(aa)(4))) pursuant to the standards adopted under section 2903 of the Public Health Service Act (as added by section 101). Such pilot program should be based on experience gained through previous demonstration projects conducted by the Secretary, including demonstration projects conducted under sections 1866A and 1866C of the Social Security Act (42 U.S.C. 1395cc–1; 1395cc–3), section 649 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2322), and other relevant work conducted by private entities.

(2) EXPANSION.—After conducting the pilot program under paragraph (1) for not less than 2 years, the Secretary may transition and implement such program on a national basis.

(3) FUNDING.—

(A) IN GENERAL.—Payments for the costs of carrying out the provisions of this subsection shall be made from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t) (in this subsection referred to as the ''Trust Funds''), as determined appropriate by the Secretary.

(B) LIMITATION TO ENSURE BUDGET NEUTRALITY.—The Secretary shall ensure that the total amount of expenditures from the Trust Funds in a year does not exceed the total amount of expenditures from the Trust Funds that would have been made in such year if this subsection had not been enacted.

(C) MONITORING AND REPORTS.—

(i) ONGOING MONITORING BY THE SECRETARY TO ENSURE FUNDING LIMITATION IS NOT VIOLATED.—The Secretary shall continually monitor expenditures made from the Trust Funds by reason of the provisions of this subsection to ensure that the limitation described in subparagraph (B) is not violated.

(ii) REPORTS.—Not later than April 1 of each year (beginning in the 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 expended from the Trust Funds (including all 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 during such year if this subsection had not been enacted;

(bb) the projections of the total amount that will be expended from the Trust Funds (including all amounts that will be 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 subclause (I) are reasonable, accurate, and based on generally accepted actuarial principles and methodologies, including that the steps described in subclause (I)(cc) will be adequate to avoid violating the limitation described in subparagraph (B).

(D) 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.

(E) AUTHORITY.—The Secretary shall make necessary spending adjustments under the medicare program to recoup amounts so that the limitation described in subparagraph (B) is not violated in any year.

(b) SENSE OF THE SENATE REGARDING PHYSICIAN PAYMENTS UNDER MEDICARE.—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. 1394w–4) should include provisions based on the reporting of quality measures pursuant to those adopted in section 2910 of the Public Health Service Act (as added by section 301) and the overall improvement of healthcare quality through the use of the electronic exchange of health information pursuant to the standards adopted under section 2903 of such Act (as added by section 101).

(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. 1315) 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 be based on the reporting of quality measures pursuant to those adopted in section 2910 of the Public Health Service Act (as added by section 301) and the overall improvement of healthcare quality through the use of the electronic exchange of health information pursuant to the standards adopted under section 2903 of the Public Health Service Act (as added by section 101).

(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 beneficiaires under title XVIII of the Social Security Act, the Secretary shall establish procedures to review claims data submitted under such title with respect to items and services furnished or ordered by physicians.

(B) 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.

(2) SHARING OF DATA.—Beginning in 2006, the Secretary shall periodically provide physicians with comparative information on the utilization of items and services under such title XVIII based upon the review of claims data under paragraph (1).

SEC. 303. QUALITY IMPROVEMENT ORGANIZATION ASSISTANCE.

(a) IN GENERAL.—Section 1154(a) of the Social Security Act (42 U.S.C. 1320c–3(a)) is amended by adding at the end the following:

''(18) The organization shall assist, at such time and in such manner as the Secretary may require, healthcare providers (as defined in section 2901 of the Public Health Service Act) in implementing the electronic exchange of health information (as defined in such section 2901).''.

(b) EFFECTIVE 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 uncover a cure for unmet 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 biotechnology companies can no longer