bulk phone records collection program—actually provided useful information about an individual involved in terrorist activity. In both of these cases, the government had all the information it needed to go to the phone company and get an individual court order and emergency authorization for the phone records they needed.

In both of these cases, the individuals who were identified using these phone records were arrested months or years after they were first identified, but if government agents believed that the situation was urgent, they could have used emergency authorizations to obtain their phone records more quickly. I am glad both of these cases resolved the way they did. I am proud that our intelligence agencies and law enforcement individuals were able to identify and arrest those who were involved in terrorist acts.

In one case four men in California were arrested for sending money to a militant group in Somalia. In the other case they arrested a co-conspirator of Mr. Zazi a few months after Zazi's plot was disrupted. These men committed serious crimes. They are now being punished with the full weight of the justice system.

What I don't see, however, is any evidence that the U.S. Government needed to operate a giant domestic phone records surveillance program in order to catch these individuals. I have seen no evidence—none—that this dragnet phone records program has provided any actual unique value for the American people. In every instance in which the NSA has searched through these bulk phone records, it had enough evidence to get a court order for the information it was searching for.

Getting a few hundred additional court orders every year would clearly not overwhelm the Foreign Intelligence Surveillance Court. The intelligence agencies may argue that collecting Americans' phone records in bulk is more convenient than getting individual court orders, but convenience alone does not justify the massive intrusion on the privacy of ordinary Americans. I believe it is vitally important to protect the safety and liberty of our people. I don't see any evidence that this program helps protect either. That ought to be the standard of any domestic surveillance program. If the bulk collection program doesn't protect privacy or security, then it ought to end—plain and simple.

The executive branch simply has not shown anything close to an adequate justification for this massive dragnet surveillance that has compromised the civil liberties of millions of Americans. I am not sure they ever could, but I am confident that I have not seen it as yet.

Now, let me close by way of saying that over the last few weeks we have seen extraordinary support for reform. Last week over 200 Members of the other body voted to end the bulk phone records collection program, and a number of the Members who voted against ending it at that time made it clear they have serious concerns they want to address. So there are going to be more votes. Make no mistake about it, there are going to be more votes on whether to end the bulk collection of phone records on law-abiding Americans in the 113th Congress. And there are going to be efforts to reform how the entire U.S. surveillance system works.

One of the most important reforms will be to make the significant rulings of the Foreign Intelligence Surveillance Court public, which is a goal I have been pursuing for several years.

Additionally, I believe Congress needs to reform the process for arguing cases before the court. Right now the government lawyers walk in with an argument for why the government should be allowed to do something, and there is no one to argue the other side. That is not unusual if the court is considering a routine warrant request, but it is very unusual when a court is doing major legal or constitutional analysis.

I believe Congress needs to create a way to advocate for the public—a public advocate to argue cases before the court, because making this court more transparent and more adversarial is a way to ensure that Americans can have security and liberty. Of course, the relevant provisions of the PATRIOT Act itself will be expiring in 2015. I don't think there is any reason for the administration to wait for Congress to act.

The executive branch can take action right now. They can and should continue to obtain the records of anyone suspected of connections to terror or other nefarious activity, and at the same time they can restore protections for Americans' Fourth Amendment rights. I am very interested in working with the administration on these issues, but they can move of their own volition.

One way or another, we are going to stay at this until, at this unique time in our constitutional history, we have revised our surveillance laws so we can have security and liberty. Colleagues are coming to this cause. Senator BLUMENTHAL has particularly recommended a number of constructive FISA Court changes over the last few months. I hope colleagues will support that, and I hope they will see this unique time in our history when it is critically important that these surveillance laws that I and Senator UDALL have talked about tonight can be reformed and we do it so as to protect the bedrock of American values, both security and liberty.

With that, I yield the floor.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. WHITEHOUSE. Mr. President, I ask unanimous consent that I and Senator BLUMENTHAL from Connecticut and Senator BALDWIN from Wisconsin and, if he is able to join us, Senator MURPHY from Connecticut be allowed to engage in a colloquy.

The PRESIDING OFFICER. Without objection, it is so ordered.

HEALTH CARE

Mr. WHITEHOUSE. Mr. President, my colleagues and I have come to the floor to talk about an issue that is at the heart of the discussion of our national debt and deficit; that is, health care spending.

These days around Washington, there is a regular refrain echoing through the hallways: In order to fix our deficit, we must cut Medicare and Medicaid benefits. That is wrong. That idea is, according to the former CEO of Kaiser Permanente—somebody who knows a little something about health care—and I will quote him:

> . . . so wrong it's almost criminal. It's an inept way of thinking about health care.

I could not agree more.

It was put this way by Froma Harrop, who is a columnist for my hometown paper, the Providence Journal. I will quote her: ''The dagger pointed at America's economic viability hasn't been the existence of government programs like Medicare, it's been the relentless rise in health care costs that plagues not only Medicare and Medicaid, but everyone who uses health care.''

Attacking Medicare and Medicaid ignores the fact that our health care spending problem is systemwide and not just unique to Federal programs. Our colleague Senator ANGUS KING has used the colorful metaphor that to go after Medicare and Medicaid when the problem is our health care system would be like attacking Brazil after Pearl Harbor—wrong target. It ignores the fact that we operate a widely inefficient health care system: 18 percent of our GDP compared to only 12 percent for our least efficient international competitors.

So how can we continue to stem the rise in costs and improve our wildly inefficient health care system?

Thankfully, many of the tools necessary to drive down costs have an interesting collateral benefit. They actually improve the quality of care for patients. The Affordable Care Act included 45 different provisions dedicated to redesigning how health care is delivered for the benefit of patients and taxpayers. These reforms support and encourage an ongoing delivery system reform movement—and there truly is a movement out there—driven by dedicated providers, payers, employers, and even some States that have worked for years to improve the quality and the safety and the effectiveness of health care.

We are not discussing hypothetical improvements. We are not discussing theoretical cost savings. Today I am joined on the floor by colleagues who have seen how delivery system innovators in their States have achieved real improvements to quality, real improvements in patient outcomes, and real cost savings. In Congress, we can't get over yesterday's

quarrels about repealing or defunding ObamaCare, but out there in the real world health care leaders across the country are innovating forward, places such as the Cleveland Clinic in Ohio, Intermountain Healthcare in Utah, Geisinger Health System in Pennsylvania, Gundersen Lutheran in Wisconsin, Palmetto Health in the Carolinas, and in Rhode Island, among other places, our own Coastal Medical.

One Rhode Island practical example: When intensive care unit staff follow a checklist of basic instructions—washing their hands with soap, cleaning a patient's skin with antiseptic, placing sterile drapes over the patient and so forth—rates of infection plummet, and the costs of treating those infections disappear—no infection, no cost.

These reforms have the triple benefit of protecting Medicare and Medicaid, improving patient outcomes, and dialing back health care spending for all Americans. How big is it? The President's Council of Economic Advisers has estimated that we could save approximately $700 billion—that is billion with a ''b''—$700 billion every year—every year—in our health care system without compromising health outcomes. The Institute of Medicine took a look at the same question. They put the savings number at $750 billion.

Other groups are even more optimistic. The New England Health Care Institute has reported that $850 billion could be saved annually. The Lewin Group and former Bush Treasury Secretary Paul O'Neill—who as the CEO of Alcoa is deeply involved in the reform efforts in Pennsylvania that have been very successful and knows a fair amount about this—they estimate an annual savings of a staggering $1 trillion.

Whatever the exact number is, what is clear is there is huge potential for savings in our health care system while improving or maintaining the quality of care. Since the Federal Government does 40 percent of America's health care spending, when we get that right, taxpayers as well as patients become big winners from these reforms.

I will close with two points: First, many of us are asking the Obama administration to set a hard cost savings target for these delivery system reform efforts. It may be $750 billion. Pick a number that will be a target to be actually achieved. A target—a measurable goal—will focus and guide and spur the administration's reform efforts in a manner that vague intentions to ''bend the health care cost curve'' simply cannot.

Second, we need to put the full force of American innovation and ingenuity into achieving that serious cost savings target for our Nation's health care system. It is hard to do that without that target to strive toward.

This is an issue where our Republican colleagues should be able to join us to accelerate these reforms in our health care delivery system and to move forward beyond tired-out calls to repeal ObamaCare so we can deal with the ongoing reality of health care reform.

Let's give American families the health care system they deserve. Instead of waste and inefficiency, poor outcomes and missed opportunities, let's give them a health care system that is the envy of the world.

I yield for my colleague, Senator BALDWIN.

Ms. BALDWIN. Mr. President, I thank my colleague for convening us and for giving us an opportunity to discuss the important topic of delivery system reform and to highlight some of the innovations that are occurring in our own States.

I heard Senator WHITEHOUSE talking about moving forward. It is actually the motto of the State of Wisconsin. One simple word: ''Forward.'' Throughout our State's history, that motto has well represented our leadership in extending high-quality and affordable health care.

Our health care providers and payers have pioneered forward-looking reforms that improve the quality of care and lower costs for families and for businesses. We are home to world-class, highly integrated health care systems. We make quality and outcomes data widely accessible to providers so they can measure their success against their peers. We stand at the forefront of using and advancing health care information technology. All of this affords some of the highest quality care in the country at a competitive cost.

Congress has a lot to learn from Wisconsin's health care delivery systems. A recent Institute of Medicine report reinforced what we have known for a long time: that geographic variation in health care spending and utilization is real and that variations in health care spending are not consistently related to health care quality. For every State such as Wisconsin with higher quality outcomes and lower costs, there are five other States faring worse. Even within States, the regional variation in health care spending and quality is troublesome.

Unfortunately, instead of advancing and fostering forward-thinking innovations such as those working in Wisconsin, far too many of my fellow lawmakers are looking backward when it comes to health care. In the House of Representatives, the Republican leadership has scheduled votes to repeal or defund the Affordable Care Act almost 40 times. Some State governments—including, unfortunately, my own—have refused to move forward with America's new health care law and are undermining its effectiveness at every chance possible. Now some of my colleagues in the Senate are threatening to shut down the government if investments in our health care system are not stripped out of our budget entirely.

Families and businesses in Wisconsin and across the country are tired of these political games. For as long as some of my colleagues and some of the Governors across this country remain glued to the past, waging political fights based on pure ideology, we lose golden opportunities to move health care reforms in our country forward. We should all be focused on building a smarter and more affordable health care system, not trying to tear down the law of the land.

That is why I am so proud to stand on the floor with my colleagues tonight, committed to moving our Nation's health care system forward. By building on the best reforms to our health care delivery system that are embedded within the Affordable Care Act and making new improvements to how we deliver care in our country, we will lower health care costs, improve quality and strengthen our economic security and reduce the deficit. Better yet, we will have more States with health care systems such as Wisconsin's, and Wisconsin's system will be improved as well.

The possibilities are exciting. I think one of the things Senator WHITEHOUSE just mentioned bears repeating: There is widespread agreement that significant savings can be achieved in our health care system without compromising the quality of care. The figures he cited bear repeating: The Lewin Group and the former Treasury Secretary Paul O'Neill have estimated that we could save $1 trillion per year without affecting health care outcomes by enacting smart, targeted health care delivery reforms. The New England Health Care Institute pegged that number at $850 billion annually, the Institute of Medicine estimated this number to be $750 billion, and the President's Council of Economic Advisers foresees savings at $700 billion a year. No matter the exact figure, these are impressive savings that would strengthen our entire Nation.

The Affordable Care Act has sparked this hard work of transforming health care delivery. The law provides health care practitioners with incentives to better integrate care, increase quality, and lower costs. These efforts are producing impressive results in Wisconsin. For example, the Pioneer Accountable Care Organization Program has offered financial incentives to meet quality and Medicare savings benchmarks. Bellin-ThedaCare Healthcare Partners in northeast Wisconsin has excelled with this program. In its first year of participation, Bellin-ThedaCare earned $5.3 million in shared savings and lowered costs for its 20,000 Medicare patients by an average of 4.6 percent. While not every pioneer ACO has been as successful, the CMS Office of the Actuary believes this program could save Medicare up to $1.1 billion over 5 years by simply better coordinating care.

Wisconsin boasts six additional health care providers participating in the law's traditional Accountable Care Organization Program which the Department of Health and Human Services estimates could save up to $940 million over 4 years. Wisconsin health care providers are also taking part in

the Affordable Care Act's Partnership for Patients to improve health care quality. This public-private partnership engages hospitals, businesses, and consumer groups with the goal of preventing injuries and complications in patient care—including hospital-acquired conditions. The administration estimates that reducing medical errors and preventing conditions will save up to $35 billion in health care costs.

Another public-private partnership—the Affordable Care Act's Million Hearts Initiative—is preventing heart attack and stroke. Cardiovascular disease costs this country $440 billion per year in medical costs and lost productivity. The initiative seeks to deliver better preventive care to stop 1 million strokes and heart attacks by the year 2017—in part by utilizing innovative technology. Wisconsin's own Marshfield Clinic designed a winning mobile application for the initiative. The app will encourage patients to get their blood pressure and cholesterol checked and to work with their health care providers to improve their heart health.

Finally, the Affordable Care Act has empowered the CMS Innovation Center to develop new ideas to improve health care quality and lower costs for people enrolled in Medicare, Medicaid, and the Children's Health Insurance Program. A number of the center's projects are currently underway in Wisconsin. For example, the Children's Hospital of Wisconsin, Aurora HealthCare, and the Wheaton Franciscan Healthcare system have created a model to decrease emergency room visits for children. The estimated 3-year savings of that project is almost $3 million. In addition, the Pharmacy Society of Wisconsin is utilizing a provision in the Affordable Care Act to better integrate pharmacists into clinical care teams. That initiative is set to save over $20 million in 3 years.

This represents a small sampling of the delivery innovations being promoted through the Affordable Care Act that are saving us money right now. These parts of the law are empowering Wisconsin health care providers to provide higher quality care at reduced costs. Public officials who advocate for repealing the Affordable Care Act would end these impressive initiatives as well. Instead, we must build on these delivery reforms, as so much more can be done.

To name two priorities, Wisconsin cardiologists have developed an innovative integrated network called SMARTCare to deliver better more efficient care for a vulnerable patient population. The Department of Health and Human Services should encourage this coordinated care model by investing in it and measuring its results.

We should improve the law to increase access to Medicare claims data. The Wisconsin Health Information Organization currently holds over 65 percent of health insurance claims data in the State—from private insurers and from Medicaid. The organization shares that data with health care providers so doctors can compare their performance—in terms of quality and cost—against their peers. This data-sharing promotes competition and it lowers cost. But due to current law, the organization cannot access Medicare data. If we open Medicare claims data, we will further improve quality and we will lower costs.

Lawmakers have a clear choice: Go backward and try for the 40th time to repeal the Affordable Care Act or put progress in our country ahead of politics. We welcome our colleagues to join us in moving our country and our health care delivery system forward.

I now yield for Senator MURPHY.

Mr. MURPHY. Mr. President, I thank very much Senator BALDWIN and thank the State of Wisconsin for, in a lot of ways, leading the way and showing us what is possible when it comes to delivery system reform.

It is pretty amazing some of those statistics Senator BALDWIN used when she talked about how much waste there is in the system today. The estimates are from the Council of Economic Advisers, $700 billion; from the New England Healthcare Institute, $850 billion. To put that in context, even if the median of the two is right—somewhere in the high $700 billion range—that is $100 billion more than we spend every year on the military. That is enough money to provide coverage for 150 million more Americans. That is enough to pay the salaries of every single first responder personnel in the country, including firefighters, police officers, and EMTs for over a decade.

It is an enormous amount of money that we are wasting today because we have a reimbursement system, as Senator WHITEHOUSE said as well, that essentially rewards providers and hospitals and health care systems for providing volume rather than providing quality.

We understand there is not a single health care provider in the country that does not get into this if not for their desire to provide quality health care. There is no malevolent motive involved here. But, ultimately, when you have to keep your doors open—as a medical practice, as a hospital, as a nursing home—and you get paid more the more medicine you practice and the more treatments you order and the more tests you have your patients undergo, then you are going to follow the money. It is time we reorient our reimbursement model under Medicare and Medicaid, and in partnership with our private insurers, so we are reimbursing based on the quality of medicine and the quality of the outcomes you provide rather than on how much stuff you order or prescribe.

Let me talk about three examples of how we have succeeded already when it comes to changing the model of reimbursement.

First, the issue of readmission rates. When you go into a hospital for a surgery, that hospital is going to get a set fee for the surgery and for the amount of time you spend in the hospital afterwards. It is called a bundle payment. Bundle payments are good because what it does is it encourages you to essentially use your resources wisely because you are not going to get paid more if you keep the person in the hospital for 10 days than if you keep the person in the hospital for 5 days.

But here is the problem when it comes to the care people were getting after a particular surgery. Because the hospital got a set payment for that period of time, they had an incentive to push the person out of the hospital as quickly as possible. That was an incentive not only because the payment itself did not get bigger the more amount of time you were in the hospital, but it also was incented that way because if the person went home too early and then they came back again to the hospital, the hospital got a second bundle payment when they came back. And if they came back a third time and a fourth time, they got another payment.

So what was happening is there was an incentive to send people home before they were ready because not only would that save you money on the first bundled payment, but it actually made the hospital or the health system money in the long run because the person came back a second or a third or a fourth time.

I do not think there was a single hospital in the Nation that was deliberately misaligning their care so they would have people coming back to the hospital a second or a third or a fourth time. I am not suggesting people were trying to game the system in that way. But what certainly was happening was that without an incentive that pulls you the other way—get the care right the first time—there was, unfortunately, insufficient care being provided.

So the health care bill says: Listen, we will pay you for maybe the first readmission, maybe for really complicated procedures we will pay you for a second readmission, but at some point there has to be an end to this model. At some point it has to be up to you as the hospital or as the health care provider to get the care right the first or the second time so we are not on the hook for readmissions occurring times three or times four. That is a pretty simple change, but it can save hundreds of millions of dollars.

The second example is accountable care organizations. We set up a bunch of Pioneer accountable care organizations. These are bigger systems of care, where you have primary care doctors networked with specialty care providers, working under one umbrella to coordinate the care of the sickest patients. There are different numbers, but they all tell the same thing, which is that the sickest 5 or 10 percent of patients in the country are taking up about 50 percent of annual medical expenditures. So if you do a better job of

coordinating the care of that small percentage of the medical population, you are going to save a lot of money.

Accountable care organizations can do that. Instead of having siloed care, where a co-morbid patient goes to a primary care doctor over here, then a specialist here, then a specialist there, if they are all under one roof and they are talking to each other, then you can save a lot of money just by coordination. That is the theory. So the health care reform act put that theory into practice. It set up a pilot program by which Pioneer accountable care organizations—essentially, a beginning set of accountable care organizations—would be set up under a model through which Medicare would say: If you save money, we are going to deliver back to you some of those savings so that, in fact, there is not a disincentive to practice less medicine because if you practice less medicine, Medicare will take some of the savings and it will share with you some of the savings.

Well, we have only had a year or so of returns from this model, but the results are pretty stunning. The average increase in costs per beneficiary has been—in the Pioneer ACOs—less than 50 percent of that for non-Pioneer ACO models. That is a pretty significant savings.

In addition, go back to this question of readmissions. In 25 of the 32 Pioneer ACOs, there was a lower risk-adjusted readmission rate than in non-Pioneer ACOs. Coordinated care where you are reimbursing an organization as opposed to just the individual physicians actually saves you a lot of money.

Then third, the issue of outliers. What you find when you look at the data—and it may be that Senator WHITEHOUSE talked about this—is that sometimes 60, 70, 80 percent of the system is practicing good medicine at the right cost, and it is really only a small handful of providers that are way outside of the median and all you have to do, when it comes to some subsets of reimbursement, is bring those outliers back into the median.

Home care was a great example. In the Accountable Care Act, we said that for home care providers that had utilization rates that were far outside the median, we were going to stop reimbursing for those episodes that were far outside the median. CBO was not sure how to score it because they did not really know that was going to change people's practice. But it did. And it is estimated that single change, in controlling for the handful of outliers when it comes to high utilization rates in the home care line item, is going to get us almost $1 billion in savings over a 10-year period of time.

When you look at home care, actually it is only a handful of areas in which you have these outpaced utilization rates compared to the rest of the country. It is places in Texas, it is places in certain counties in Florida. Most of the country is right where you should be. So part of reforming our delivery system is also taking care of these outliers.

We have seen savings, whether it be in controlling readmission rates, setting up accountable care organizations, or taking on outliers within our home care system.

Now it is time to do more because, before I turn it over to my good friend Senator BLUMENTHAL, here is where the rubber hits the road.

In about 10 years, Medicare starts taking in less money than it sends out. It does not go bankrupt all of a sudden, but it starts to become fiscally insolvent. There are only a handful of ways to stop that reality from happening. You can either ask beneficiaries to pay more out of pocket; you can cut their benefits, give them less; you can ask people to pay more into the system while they are working or you can make the system more efficient.

It may be that we have to do a mix of those. But clearly the first three are not that palatable: reducing benefits, increasing copays, or increasing taxes. This is not a partisan issue. Both sides agree that in 10 years we have an accounting problem in Medicare. Both sides agree that we have to make changes today in order to stop that crisis from occurring.

It strikes me that if the most conservative Republican and the most liberal Democratic sat down at a table and looked at those four options—increased copays, reduced benefits, increased taxes, or increased efficiencies—we would all agree. The conservative Republican and the liberal Democrat would agree, along with probably every other Member of this body, that is the first place you should go is to reduce inefficiencies. That is what the delivery system provides. So we have set up a working group here in the Senate which is beginning its work this week, that Senator BALDWIN, Senator WHITEHOUSE, Senator BLUMENTHAL, I, and others will be building over the course of the late summer and fall. We hope it will draw interest from both sides of the aisle so we can start to put some meat on the bones when it comes to the changes in our delivery system that can be made to increase efficiencies so as to forestall the need to balance the Medicare books on the backs of taxpayers, workers, or beneficiaries.

With that, let me yield the floor to my great friend from Connecticut, someone who both as a Senator and our State's attorney general has been fighting for health care consumers for a long time, Senator BLUMENTHAL.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. BLUMENTHAL. Mr. President, I want to thank my colleague, CHRIS MURPHY. Senator MURPHY has been a long-time champion on this issue. My colleagues may wonder why two Senators from Connecticut, both of our Senators, are here on the floor and part of this working group seeking to lead on this critically important issue of health care delivery.

The answer is we come from a State where it is working. We have seen the future in Connecticut's health care delivery system. It is still a work in progress, a lot of work still to be done, but Connecticut hospitals and providers and insurers and patients know it has to be our future, that cutting cost is essential to preserving and enhancing quality. Let me emphasize how important that basic principle is, because a lot of our colleagues believe there is a choice here between cutting costs and quality, that quality cannot be enhanced if we cut costs.

In fact, the opposite is true. Cutting the cost of health care is key to enhancing and improving quality. It is the way we will reduce premature discharges from hospitals, that we will diminish the number of discharges from hospitals without proper rehabilitation plans, and cut the number of hospital-acquired infections. It is not only possible to do but it is essential. It is a way we avoid the false choice—and it is a false choice—between preserving Medicare on the one hand and avoiding increasing copays, decreasing benefits, or increasing taxes, as my colleague from Connecticut has said.

I reject every one of those options as necessary to preserving Medicare. Increasing copays, decreasing benefits, or increasing taxes is not the way. In fact, increasing efficiencies and avoiding unnecessary wasteful and indeed harmful costs are necessary to preserve Medicare.

My mother taught me a number of things. She said, No. 1, if you don't have something nice to say about someone, don't say anything. So I am not here to say not-so-nice things about the folks who say we ought to cut Medicare benefits. But I would oppose those kinds of cuts as unnecessary and harmful.

She also said an ounce of prevention is worth a pound of cure. In fact, that basic truth is what will help save our health care system. Prevention of costs, prevention of illness, prevention of obesity and smoking, and other kinds of diseases and conditions that lead to increased health care costs are essential to this effort.

My mother said also listen to your younger brother. My brother, Dr. David Blumenthal, has been a pioneer and an expert in this area. As much as it pains me to acknowledge that my younger brother knows a lot more about this subject than I do, in fact, he has been able to enlighten me and many of our colleagues here on this point. I mention him and the others who are experts and pioneers in this effort. He is one of many who have advised and provided that kind of enlightenment.

Because there is no more kind of guesswork as to whether advances can be made in this area by cutting costs and raising quality. It has been documented. There are projections. It can be costed out. It can be scored, in my view. It can be the basis for action by my colleagues here in seeking to cut

costs that are skyrocketing out of control.

I have seen these reforms at work throughout the State of Connecticut. This issue is of national importance, but it hits hospitals and providers in every one of our States. I have seen it and listened to folks who work at places such as St. Vincent's and Bridgeport Hospital, in Bridgeport; St. Mary's Hospital in Waterbury; Yale-New Haven and Greenwich Hospital, Middlesex Hospital. All around the State of Connecticut, I have seen the checklists at work, the protocols for hand washing, the increased attention to quality care that has helped reduce costs. They have helped improve patient care while reducing cost. They reject this false choice between quality and cost cutting. Both are possible. Both are essential.

We hear so much rhetoric about the Affordable Care Act in Washington. But in Connecticut, we see tangible examples of how it is working and making a difference. The implementation of the Affordable Care Act is a historic opportunity for continuing this work and expanding it nationwide. We need to continue our dedication to health care reform.

My colleagues and I have come to the floor today to call for smart reform that helps patients and avoids harm to them, and does not discourage providers from being a part of a Federal health care program. In fact, we need to identify areas of reforms within the health care system that we can address that will strengthen health care in this country and address the serious concerns about the skyrocketing costs of health care.

We have seen a slowdown in the growth of national health care expenditures over the past year. But slow growth certainly does not mean a decrease in overall expenditures. Smart policy decisions require that we address the ongoing problem of health care spending in this country, and turn a corner for the good by reducing the current costs.

I am concerned that there are shortsighted strategies, such as taking money from the Prevention and Public Health Care Fund established under the ACA, which has been a tactic unfortunately used by both parties in financing programs. That tactic will undermine our long-term efforts at reducing health care spending. The Prevention and Public Health Fund is used in Connecticut for programs such as mental health services and substance abuse prevention, as well as public health research and surveillance.

These measures will ultimately result in lower health care spending through prevention and preventive health care. But we need to stay committed and stay the course. What we need to do now is to continue to work toward developing a sustainable health care system, through structural reforms such as the accountable care organizations, health maintenance organizations, patient-centered medical homes that have provided advances in this area, and have created provider organizations that lead to greater provider acceptance of responsibility for health care outcomes in their patients.

Measuring the success of those organizations requires taking a closer look at whether the savings and outcome improvements actually materialize. We have to be hard-headed and clear-eyed about whether they are working. The metrics must be applied. We need to measure success. Measurements are possible; as I said at the outset, no longer a matter of guesswork. There are scientific-based measurements.

The success of these organizations will have more to do with how they are run than with how they are structured. As sophisticated as many of our health systems are, the development of process goals has only recently become a consideration. The Association of American Medical Colleges recommends, for example, the use of surgery checklists through their best practices program.

Peer-reviewed studies have shown that the use of comprehensive checklists is associated with reductions in complications and mortality during surgery. But they are most successful when health care organizations subscribe to a culture of safety. That culture of safety and prevention is essential.

Some hospitals in Connecticut have been rewarded through the Medicare Program for their commitment to improving quality through the use of process measures: Bridgeport Hospital, St. Mary's Hospital in Waterbury, Middlesex Hospital have all seen increases in reimbursement rates through the Value Based Purchasing Program.

Again, the Federal Government can provide incentives and encourage and support this effort. Manchester Memorial Hospital, Hartford Hospital, and Rockville General Hospital all have avoided Medicare penalties by lowering their readmission rates. While payment differences for these programs represent a small portion of the overall Medicare payment, hospitals should continue to be rewarded for addressing these issues.

I want to conclude by drawing attention to some of the innovative work being done in my State of Connecticut around delivery reform and data collection. I have mentioned the importance of measurements and metrics. Much of the work is supported by grants that were made available through the Affordable Care Act. But it has been the State itself that has decided how exactly to use these funds. While Connecticut has established a working group around innovative reforms which continues to work on specific proposals and recommendations for reforming the health care system, one of the areas of focus has been to ensure integrated clinical data exchange between health care providers.

Connecticut has invested in interoperable health information technology systems and developing an all payers claims data base to create comparable, transparent information that can be better used to understand utilization patterns and enhance care access.

One of the most basic aspects of reforming any system should be a clear understanding of where the biggest problems lie, and yet we still lack the data necessary in many systems to truly understand where the unnecessary spending is taking place. It is like a diagnosis of any kind of medical condition. Facts are essential. Data is key, and I believe an investment in information technology and data collection activities will help inform payers and consumers about where our health care dollars are being spent, where they are being spent most effectively, and where we can reduce spending that will ultimately enhance health care outcomes.

Connecticut is taking a considered and insightful approach to obtaining and utilizing data while considering the needs of consumers and looking toward developing stronger programs for telemedicine and provider coordination. Technology is advancing. Data collection can help implement technology where it does the most good.

We need tangible goals for long-term reform, and that is part of the work that we have described and we are undertaking as part of our task force.

I know my colleagues this evening all agree with me that we need to continue this work and take advantage of advancing technology, the metrics that are now being sampled, of good practices, leadership of providers, the medical community, and good ideas wherever they are and whoever is willing to offer them.

I wish to thank my colleagues for joining in this effort, and I look forward to returning on this subject.

HOUSING ASSISTANCE

Mr. BLUMENTHAL. Mr. President, I wish to express my strong support for the Transportation-HUD appropriations bill and take a moment to explain an amendment that I have filed to this bill that ensures that men and women who have bravely served our country cannot be discriminated against in the housing assistance these appropriations provide.

I wish to thank Senator MURRAY and Senator COLLINS for their leadership, as well as other colleagues.

One of the problems I have heard described to me by veterans relates to discrimination when they return home after serving our country abroad and they become a civilian. One of the first things they often try to do is find a new home, often in a location far from their original home where they may not be known, where they enlisted but now have left. It may also be far from the military installation where they used to call home.

Fortunately, almost all Americans across our country rightly welcome our